Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 22, 23, Sep 8, 9, 2011	2011_099188_0014	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

Long-Term Care Home/Foyer de soins de longue durée

CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Clinical Standards, Office staff, Registered Nursing staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk through of all resident care areas, reviewed resident health care records, observed care and services to residents and reviewed various policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Minimizing of Restraining

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits sayants :

1. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector reviewed the electronic copy of the care plan for this resident and noted it does not include any restraint by a physical device. Inspector reviewed the printed care plan found it does not include any restraint by a physical device. The plan of care for this resident does not provide any direction in regards to restraining with a physical device. The licensee failed to ensure the plan of care provides clear direction to staff regarding use of a physical restraint. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits sayants :

1. The licensee received complaint letters, these written complaints concerning the care of residents were not immediately forward to the Director. The inspector obtained a copy of one of the written complaint letters when the complainant forwarded it to the Director. The inspector obtained copies of the other complaint letters during the course of the inspection. The licensee failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home are immediately forwarded to the Director.[LTCHA 2007, S.O. 2007, c.8, 22(1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits sayants :

1. Inspector reviewed the home's policy titled "Restraints - Physical, Chemical, Environmental" Policy number R6.3.0. Under the procedure section it identifies "9. RN/RPN to update Care Plan to identify type of restraint and use." Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted that the care plan for this resident was not updated to include restraining by the physical device. The licensee failed to comply with their own policy ensure that the care plan is updated to include the restraint use. [LTCHA 2007, S.O. 2007, c.8, s.29(1)(b)]
2. Inspector reviewed home's policy titled "Restraints - Physical, Chemical, Environmental" Policy: R6.3.0. Under the section labeled "points of information" it states "Every resident must have consent from family/ Power of Attorney/ Substitute Decion Maker and a Doctor's Order for the registered staff to initiate a restraint." Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted a physician's order for the restraint was obtained three months after the consent was signed. Inspector noted progress notes which identify the restraint was used for this resident during the three month period without the physicians order. The licensee failed to comply with their own policy by ensuring a Doctor's Order is obtained prior to registered staff initiating a restraint. [LTCHA 2007, S.O. 2007, c.8, s.29(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the home's written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices
Specifically failed to comply with the following subsections:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits sayants :

1. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector reviewed the electronic copy of the care plan for this resident and noted it does not include any restraint by a physical device. Inspector reviewed the printed care plan found it does not include any restraint by a physical device. The licensee failed to ensure restraint by a physical device is included in the plan of care. [LTCHA 2007, S.O. 2007, c.8, s.31(1)]
2. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident during a three month period in which no physician's order was obtained. The licensee failed to ensure the plan of care includes an order by the physician prior to use of a physical restraint. [LTCHA 2007, S.O. 2007, c.8, s.31(2)(4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits sayants :

1. Inspector reviewed the health care record for two residents with restraints on August 24, 2011. Inspector noted that the restraints were included on the residents Medication Administration Record however no signatures were noted indicating the residents were reassessed at least every eight hours by a member of the registered nursing staff. Inspector spoke with the Manager of Clinical Standards who identified that currently evaluation every eight hours by a member of the registered nursing staff is not included in the home's restraint policies or procedures. The licensee failed to ensure a resident is reassessed the the effectiveness of the restraint is evaluated at least every eight hours. [O.Reg. 79/10, s.110(2)(6)]
2. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted no documentation which identifies the removal of the device, including time of removal for the physical device. The licensee failed to ensure that the documentation includes the removal of the device, including time of removal. [O.Reg. 79/10, s.110(7)(8)]
3. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted documentation which identifies every release of the device and repositioning of the resident was not found. The licensee failed to ensure the documentation includes every release of the device and repositioning. [O.Reg. 79/10, s.110(7)(7)]
4. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted documentation in progress notes did not consistently include reassessment and monitoring, including the resident's response. The licensee failed to ensure the documentation includes all assessment, reassessment and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)]
5. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted no documentation which identifies who applied the device and the time of the application of the device. The licensee failed to ensure the documentation includes the person who applied the device and the time of application. [O.Reg. 79/10, s.110(7)(5)]
6. Inspector reviewed the health care record for a resident. Inspector noted consent for a physical restraint was signed. Inspector noted progress notes which identify this restraint was used for the resident. Inspector noted that the physician's order for the restraint was obtained or documented until three months after consent was obtained from the resident's power of attorney. The licensee failed to ensure the documentation includes the person who made the order, what device was ordered, and any instructions related to the order. [O.Reg. 79/10, s.110(7)(3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits sayants :

1. Inspector reviewed the health care record of a resident. Inspector noted a physician's order to discontinue a PRN medication. Inspector noted that the physician's order was not processed (no nurses signatures in the designated area). Inspector noted that PRN medication remained on the resident's monthly medication administration records (MAR) in February through to August, 2011. Inspector noted that this resident received the medication on two separate occasions. This medication should have been discontinued as per the physician's order. The resident received a drug that was no-longer prescribed. The licensee failed to ensure that residents receive only drugs that are prescribed for that resident. [O.Reg. 79/10, s.131(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring residents receive only drugs prescribed for that resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits sayants :

1. Inspector reviewed complaint letters and responses relating to complaints brought forward to the licensee. The response to the complaint letters was not always completed within the 10 business days. The licensee failed to ensure that for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. [O.Reg. 79/10 s.101(1)(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring a response to all complaints is issued within 10 business days by the licensee, to be implemented voluntarily.

Issued on this 9th day of September, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs