Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Original Public Report

Report Issue Date: October 25, 2023	
Inspection Number: 2023-1535-0005	
Inspection Type: Complaint Critical Incident	
Licensee: The Board of Management for the District of Nipissing East	
Long Term Care Home and City: Cassellholme, North Bay	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature**
Additional Inspector(s) Inspector Loviriza Caluza #687 observed this inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-20, 2023

The following intake(s) were inspected:
- One intake, related to Improper/ incompetent care of resident;
- One intake, which was a complaint related to a fall; and
- One intake, related to an allegation of neglect of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was provided with an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and summary
A resident was involved in an incident, in which the resident sustained an injury. The resident's Physician ordered a specified diagnostic exam that was conducted at an external health care facility. The resident's SDM was not made aware of the results until a number of days after the home received the results of the diagnostic exam.

A Nurse Manager (NM), and the Director of Care (DOC) both verified that there was a delay in communication about the results of the diagnostic exam, and that the resident's SDM did not have the opportunity to fully participate in the development and implementation of the resident's plan of care.

Not providing the SDM with an opportunity to fully participate in the development and implementation of the resident's plan of care posed a minimal risk to the resident.

Sources: A resident's progress notes and health records; interviews with a NM and the DOC.
[690]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from neglect by a Registered Practical Nurse (RPN).

The Ontario Regulations (O. Reg.) 242/22, s. 7., defines neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and summary:
A resident had a specified diagnosis, and had a medication order that was to be administered when the resident was displaying symptoms of the diagnosis.

An RPN verified that staff reported to them that the resident appeared to be displaying symptoms related to the diagnosis. The RPN assessed the resident, observed the symptoms, and was aware of the medication order; however they did not administer the required medication.

Not administering the required medication to the resident, posed a moderate risk to the resident. The impact to the resident was minimal as the resident did not have a negative outcome as a result of the incident.

Sources: A Critical Incident System (CIS) report; A resident's Physician's orders; the home's investigation notes; the home's policy titled "Abuse, Neglect and Retaliation Prevention, #05-03", last revised May 6, 2023; interviews with an RPN, NM, and the DOC.
[690]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting a resident.

Summary and Rationale
A resident was being provided assistance by staff to perform an Activity of Daily Living (ADL) with a specified device. While staff were providing assistance, the resident sustained an injury. At the time of the incident, the resident's care plan indicated that the resident required a specified type and size of device to be used when assisting the resident with the ADL.

The home's investigation notes indicated that the cause of the incident was related to staff using a different type and size of device while assisting the resident with the ADL, and that the device was not used properly.

A Personal Support Worker (PSW), NM, and the DOC all confirmed that staff did not use the device correctly when they provided assistance to the resident, and that it was not the correct type, and size of device.

Not using the correct type and size of device while providing assistance to the resident presented a moderate risk that resulted in a moderate impact to the resident as they sustained an injury.

Sources: A CIS report; a resident's care plan; the home's investigation notes; interviews with PSW staff, a NM, and the DOC.
[690]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the home complied with the requirements set forth in the homes fall prevention and management program, when a resident was involved in an incident that caused them to sustain a specified injury.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the home's falls prevention and management program is complied with.

Specifically, registered staff did not comply with the home's falls prevention and management program; which required the implementation of a specified assessment tool if the resident sustained a specified type of injury.

Rationale and Summary
A resident was involved in an incident that caused them to sustain the specified type of injury. Progress notes documented in Point Click Care (PCC) indicated that staff were to complete the assessment tool at certain times for a specified duration. The inspector could not locate any documents in the resident's chart to indicate that the assessment tool was completed.

The DOC verified that registered staff did not complete the assessment tool as per the home's policy.

Sources: A resident's health care records; progress notes; the home's policy titled Fall Prevention - Falls Assessment and Risk Screening CS-F.1", last revised August 4, 2021, and Policy CS-F.4", last revised August 25, 2021; interviews with a NM, and the DOC.
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