Ontario

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

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: November 6, 2024

Inspection Number: 2024-1535-0004

Inspection Type:
Critical Incident
Follow up

Licensee: The Board of Management for the District of Nipissing East

Long Term Care Home and City: Cassellholme, North Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16, 17, 18, 19, 20, 2024

The following intake(s) were inspected:

- One intake, related to resident to resident abuse,
- Two intakes, related to Follow Up orders pertaining to reporting to the Director, resident to resident altercations and duty to protect,
- Three intakes related to staff to resident neglect,
- One intake regarding improper/incompetent care of a resident by staff and
- One intake, related to resident to resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1535-0002 related to FLTCA, 2021, s. 28 (1) 2.

Order #003 from Inspection #2024-1535-0002 related to O. Reg. 246/22, s. 59
Order #001 from Inspection #2024-1535-0002 related to FLTCA, 2021, s. 24 (1)

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in an area or a medication cart, (ii) that was secure and locked as the Inspector observed resident topical medications in an unlocked area of the home.

Sources: Observations and interview with the RPN team lead.

On September 18, 2024, immediately after the Inspector observed the topical medications, the RPN team lead removed them and ensured they were secured in a locked drawer of the treatment cart.

Date Remedy Implemented: September 18, 2024

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The licensee's policy titled "Abuse, Neglect and Retaliation Prevention, last reviewed May, 2024, directed the supervisor to remove the staff member accused of resident abuse or neglect from the workplace pending the results of the investigation.

An allegation of resident neglect was reported to the home's management team; however, the staff member suspected of the alleged neglect was not immediately removed from the home pending the outcome of the home's investigation.

Sources: CIS report, staff schedule, and the home's policy titled, "Abuse, Neglect and Retaliation Prevention", last reviewed May 2, 2024; and interviews with a Registered staff member and the Director of Support Services and Quality Assurance.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

a) Specifically allegations of neglect of a resident.

Rationale and Summary
On a specific day, an individual informed a staff member that a resident had not received care. The allegation was not immediately reported to the Director.

Sources: Critical Incident report, home's investigation files, and the home's policy titled, "Abuse, Neglect and Retaliation Prevention", last reviewed May 2, 2024; and interviews with two different staff members.

b) Specifically suspected neglect of multiple residents by a specific Registered staff member.

Rationale and Summary
On a specific day, a staff member informed another staff member that they had failed to provide care to residents assigned to them on a specific home area during their shift.

The RN was notified of the allegation however they did not report the suspected neglect to the Director until later that day.

Sources: Critical Incident report, home's investigation file, and the home's policy titled, "Abuse, Neglect and Retaliation Prevention", last reviewed May 2, 2024; and interviews with the three staff members.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments and reassessments, interventions and the

resident's responses to interventions are documented.

Rationale and Summary
A PSW reported seeing a resident in pain during their shift on a specific day and informed a RPN of their findings. They stated that when they returned to re-assess the resident with the RPN, they both found the resident was not in pain. There resident's electronic health record contained no documentation of the staff members' observations or assessments.

The home's policy, titled "Pain Management Protocols," required staff to document their pain assessments in the resident's electronic health record, using specific pain assessment tools.

Failure to ensure that pain assessments were documented by staff members may have resulted in insufficient communication about a residents pain and pain management.

Sources: CIS report, the resident's electronic health record, documentation survey v2. for the specific day, the home's investigation file, and the home's policy titled, "Pain Management Protocols", last reviewed August 4, 2021; and interviews with three staff members.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

a) Specifically related to auditing staff use of personal protective equipment (PPE).

Rationale and Summary
According to Additional Requirement 2.1 of the IPAC standard for LTCHs, the licensee was to ensure that quarterly real-time audits of the selection, and donning and doffing of PPE were completed.

The home was requested to provide all audits of staff selection and donning/doffing of PPE completed within the most recent quarter.

The home was unable to provide the requested PPE audits.

The IPAC Manager acknowledged that the quarterly PPE audits were not completed as required.

Failure of the IPAC Manager to conduct regular quarterly audits of staff use of PPE may have increased the risk of infection transmission and spread in the home.

Sources: The IPAC standard for Long-Term Care Homes (LTCHs), revised September 2023; and an interview with the IPAC Manager.

b) Specifically related to point-of-care signage.

Rationale and Summary
According to Additional Requirement 9.1 (e) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was to ensure that Additional

Precautions included point-of-care signage indicating that enhanced IPAC control measures were in place.

During the inspection, yellow isolation caddies with PPE and various enhanced precautions signage were observed on multiple doors to resident bedrooms on the third floor; however, the signage did not specify which resident in the room required the enhanced precautions. There was no additional information about the precautions at the residents' bedsides.

Failure to ensure that the point-of-care signage indicated which resident in the room required the additional precautions, may have resulted in staff members, visitors, and co-residents not implementing the necessary enhanced precautions while in the residents' rooms, potentially exposing others to the spread of infectious microorganisms.

Sources: Observations on two different home areas; two different resident health records, registered nurse third floor resident list, Floor Plan Staff Assignment List, and the home's policy titled, "Enhanced Barrier Precautions", last revised March 2024; and interviews with a PSW, a RN, and the IPAC Manager.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use, as specified by the prescriber.

Rationale and Summary
A resident was prescribed a scheduled pain medication.

A review of the resident's electronic Medication Administration Record (eMAR) revealed that the medication was not administered as directed.

The RPN and NM confirmed that the other RPN did not administer the resident's medications as prescribed.

Sources: CIS report, the resident's electronic health record, the home's investigation file, and interviews with a RPN and a NM.

COMPLIANCE ORDER CO #001 Plan of care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

Develop and implement an auditing process to ensure that three specific residents

care requirements are provided based on their care plan. The audits must be completed for a minimum of three weeks, or longer if concerns are identified. A record of the audit shall be kept including the date of the audit, who completed the audit and any corrective action implemented as a result of the audits.

Grounds
The license has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) Specifically, that a resident's plan of care for ensuring that two staff provided assistance to the resident for hygiene care.

Rationale and Summary
A Personal Support Worker (PSW) provided care to a resident without the assistance of another staff member, which resulted in the resident sustaining injuries.

A review of the residents' care plan identified that the resident required two staff to provide assistance for care.

An interview with a Nurse Manager (NM) concluded that the PSW did not follow the resident's plan of care by not ensuring two staff were assisting with care.

Sources: CI report, home's investigation documents and resident care plan; interviews with a NM and a RN.

b) Specifically, a resident's plan of care for personal hygiene, grooming, dressing, and preferences was followed.

Rationale and Summary
The care plan for the resident stated that they required assistance with Activities of

Daily Living (ADL's). The care plan also stated that staff was responsible for ensuring that the resident received care from specific individuals only.

The PSW confirmed that the plan of care was not followed, and that they did not provide the care as outlined in the residents care plan.

Failure to ensure that staff followed the care plan put the resident at risk of not receiving the assistance they required to meet their personal preferences and personal hygiene, grooming, and dressing needs.

Sources: The resident's electronic health record; home's investigation file; and interviews with two PSWs and NM.

c) Specifically, that a different resident was provided care as specified in their plan of care.

Rationale and Summary
The resident's care plan included a focus for pain related to their disease process. The care plan stated that the resident would be monitored for verbal and non-verbal signs of pain, with the goal of minimizing pain and facilitating comfort.

A review of the electronic medication administration record (eMAR) for a specific day, revealed that the resident's pain assessment was not completed on two separate occasions that day.

The NM confirmed that the Registered staff did not follow the plan of care for the resident; that the pain assessments were not completed as required.

Sources: The resident's electronic health record and the home's investigation file; and interviews with the RPN, two different RNs and and a NM.

This order must be complied with by December 20, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.