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

Public Report

Report Issue Date: April 4, 2025
Inspection Number: 2025-1535-0003
Inspection Type: Complaint 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): March 24-27, 2025.
The following intake(s) were inspected:

- Intake, related to Follow-up for compliance order, issued to the home, regarding continence care and bowel management, with a compliance due date (CDD) of February 28, 2025;
- Intake, related to an infectious disease outbreak and,
- Two Intakes, related to a complaint and critical incident for concerns with a resident's care.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1535-0001 related to O. Reg. 246/22, s. 56 (2) (g).

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

Continence Care
Infection Prevention and Control
Falls Prevention and Management

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)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision maker (SDM) was provided an opportunity to participate in the development and implementation of the resident's plan of care when there had been a change in the resident's status.

There had been an incident, in which there had been a noted change in the resident's health condition. Registered staff identified that the resident's SDM was not notified of the resident's status until the following day.

Sources: complaint intake; CI report; a resident's health care records; the home's investigation notes; the home's policy titled, "Fall Prevention-Falls Assessment and Risk Screening", last revied October 28, 2024; and interviews with direct care and registered staff, Unit Manager, Manager of Clinical and QA, and the Interim Director of Care (DOC).

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care revised, based on the outcome of the assessment when they were observed to have a change in their condition..

Direct care staff documented progress notes for a five day period, that the resident was observed to have a change with a specific activity of daily living (ADL), which they all identified was a change for the resident; they documented the change was reported to the registered staff. The Inspector was unable to locate an assessment had been completed when the change with the resident had occurred, and their plan of care had not been revised.

Sources: complaint intake: CI report; a resident's health care records; the home's internal investigation notes; and interviews with direct care and registered staff; Unit Manager, Manager of Clinical and QA, and the Interim DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that when an outbreak had been declared the

Director was not notified immediately.

The North Bay Parry Sound District Health Unit (NBPSDHU) declared the home in an infectious disease outbreak and the Director was not notified until the following day.

Sources: CI report; the home's outbreak documents; the home's policy titled, "Outbreak Management – Procedure For", revised January 2025: and interviews with the IPAC Lead.

COMPLIANCE ORDER CO #001 Pain management

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

1. Re-educate the registered staff identified on the home's pain management program, specifically, when to complete a pain assessment and what measures to take when a resident's pain is not managed by initial interventions.

2. Maintain documentation of the re-education provided, including, but not limited to, the date, attendees, the individual who provided the re-education, and the content of the re-education.

Grounds

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the registered staff completed a pain assessment. The resident had been exhibiting pain to an identified area, after an incident had occurred. Registered staff identified

that the resident had refused the initial interventions, had not attempted alternate pain management interventions, and had not completed a pain assessment.

There was risk to the resident for not having a pain assessment completed when the initial pain management interventions were ineffective, as they continued to exhibit signs of pain.

Sources: complaint intake: CI report; a resident's health care records; the home's internal investigation notes; the home's policy titled, "Pain Management Protocols", last revised December 2024; and interviews with direct care and registered staff; Unit Manager, Manager of Clinical and QA, and the Interim DOC.

This order must be complied with by May 23, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

1. Develop and implement an auditing process to ensure that all residents are being supported to perform hand hygiene prior to receiving meals and snacks.

2. Conduct and document the audits for a period of four weeks. The documentation must include, but not limited to, the area of the audit, the date and time, the person completing the audit, and any corrective action taken as a result of the audit.

Grounds

The licensee has failed to ensure that the implementation of any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). The Director issued the "IPAC Standard for Long Term Care Homes" in April 2022, revised September 2023.

Additional requirement 10.4 (h) of the IPAC Standard requires the licensee to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as:

(h) Support for residents to perform hand hygiene prior to receiving meals and snacks.

Specifically, on one day, the Inspector observed six residents that had entered the identified dining room, and had not been offered or encouraged to complete hand hygiene prior to their meal service. As well, the following day, the Inspector observed three residents who had entered the dining room on another unit, which was currently in an outbreak, and they were not offered to complete hand hygiene prior to commencing consuming their meals. The meal options for both days required the residents to use their hands directly.

The NBPSDHU had conducted an IPAC assessment previously, which had identified that not all residents were offered hand hygiene during the meal service observed. The IPAC

Lead, and the Public Inspector from the NBPSDHU identified that by not offering hand hygiene to residents prior to their meal service, especially during an active outbreak, would increase the risk of transmission of infectious diseases for all residents.

Sources: Inspector observations; IPAC Standard for Long-Term Care Homes issues April 2022, last revised September 2023; Outbreak Management IPAC Checklist or LTCHs, completed 01/30/2025, by NBPSDHU: and interviews with direct care staff, IPAC Lead, and Public Inspector from the NBPSDHU.

This order must be complied with by May 23, 2025

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

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

The licensee shall:

1. Conduct an interdisciplinary review of the home's policy titled, "Outbreak Management-Procedure For", to ensure the policy outlines the process for cohorting residents during meals when an outbreak has been declared on the identified unit.

2. The process must be developed in consultation with the local public health unit and documentation of the review, who participated in the review, and all changes implemented as part of the review must be maintained.

Grounds

The licensee has failed to comply with the home's IPAC program, ensuring their Outbreak Management Plan was implemented during an Influenza A outbreak, regarding cohorting residents and staff.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the IPAC program, and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Outbreak Management–Procedure For", policy #01-1, last revised February 2025, regarding cohorting residents during an outbreak. The policy indicated that, "If the outbreak [was] on [the identified unit] only, restrict [those] residents to their unit; close the doors to the unit. Any [the identified unit] residents who eat in the [identified] dining room [were] cohorted within the dining room".

The Inspector observed an unit (currently in an outbreak) on an identified date, with the doors to the unit held open during meal service times. Residents from outbreak unit were observed leaving the unit, and consumed their meals in the another dining room with residents from another unit; which was not currently in an outbreak. The IPAC Lead, indicated that residents were not cohorted during meal service due to not having any feasible options identified for when only the identified unit was declared in an outbreak. By not cohorting residents to the identified unit, the risk of infectious diseases transmission to other residents of the home, was increased.

Sources: Inspector observations; IPAC Standard for Long-Term Care Homes issues April 2022, last revised September 2023; Outbreak Management IPAC Checklist or LTCHs, completed 01/30/2025, by NBPSDHU; the licensee's policy titled, "Outbreak Management-Procedure For", last revised February 2025; and interviews with a resident. direct care staff, IPAC Lead, and Public Inspector from the NBPSDHU.

This order must be complied with by May 23, 2025

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.