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: June 17, 2025
Inspection Number: 2025-1535-0004
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): June 9-13, 2025

The following intake(s) were inspected:

- Threes intakes, related to Follow Up to a compliance order (CO) #001, for s. 102 (2) (b), infection prevention and control, CO #002 for s. 57 (2), related to pain management and CO #003, for s. 102 (11) (b), related to infection prevention and control;
- One intake, related to an unexpected death of a resident;
- One intake, related to alleged verbal abuse of a resident by staff;
- One intake, related to an influenza outbreak.

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2025-1535-0003 related to O. Reg. 246/22, s. 102 (2) (b)

Order #003 from Inspection #2025-1535-0003 related to O. Reg. 246/22, s. 102 (11)

(b)
Order #001 from Inspection #2025-1535-0003 related to O. Reg. 246/22, s. 57 (2)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

a) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan, related to falls prevention.

A resident's plan of care identified a specific fall intervention. The fall intervention was not in place when a resident sustained a fall. The resident later sustained a second unwitnessed fall in their room. During the second fall, the same fall intervention was not followed.

Sources: Resident's health records, Critical incident report; and interviews with a Personal Support Worker (PSW), Registered Nurse (RN) and other staff.

b) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified, related to their provision of care preference.

Documentation reviews and an interview with a Registered Practical Nurse (RPN) confirmed care was not provided to a resident as per their preference.

Sources: Resident's care plan, critical incident report, and interview with RPN

WRITTEN NOTIFICATION: Plan of Care

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 failed to ensure that the a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary

A resident's care plan indicated the resident required two person assistance for care. Interviews with PSWs indicated they are able to provide care without the assistance of a second staff member.

Sources: Resident's care plan , Point of Care documentation records, interviews with PSWs and RPN

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to comply with the home's responsive behaviours policy related to resident monitoring and reporting protocols, when they failed to complete a clinical incident report for a resident exhibiting responsive behaviours.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Responsive Behaviours: Resident Altercations and Safety Precautions" and "Clinical Incident Reports and Plan of Action" policies when a clinical incident report was not completed following an incident where a resident exhibited responsive behaviours during provision of care.

Sources: Long-Term Care Home (LTCH) investigation notes, LTCH policies titled "Responsive Behaviours: Resident Altercations and Safety Precautions" and "Clinical Incident Reports and Plan of Action", resident's health records, interview with RPN

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