Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2019	2019_565647_0027	018464-19, 020329-19, 021066-19	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street 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

JENNIFER BROWN (647), AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 12 - 14, 2019.

The following intakes were completed in this Critical Incident inspection:
-one intake was related to staff to resident neglect,
-one intake was related to an unexpected death, and
-one intake was related to improper care.

Follow up inspection #2019_565647_0026 was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Operations, Director of Care (DOC), Assistant Director of Care (ADOC), Unit Coordinator (UC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee 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 Critical Incident (CI) report was submitted to the Director for Improper/Incompetent treatment of resident #003 that resulted in harm or risk of harm.

A review of the CI report, by Inspector #647, identified that when Personal Support Worker (PSW) #102 started their shift, they entered the room of resident #003 and observed an identified device in use, resulting in the resident being entrapped. The PSW immediately contacted Registered Nurse (RN) #108 who completed an assessment that identified resident #003 sustaining an injury.

A record review of the resident's health care record including an assessment and electronic plan of care indicated the resident did not require the identified device.

In an interview with Inspector #647, Unit Coordinator (UC) #113 indicated that they initiated an investigation as to who was the responsible person that applied the device. The UC indicated to the Inspector, that through the investigation, they were unable to determine who was responsible, however did acknowledge that resident #003 was not to have it.

In an interview with the Director of Care (DOC), they indicated that the home's internal investigation indicated that the home did not provide care to resident #003 as specified in the plan of care when the device had been applied.

2. A CI report was submitted to the Director for an allegation of staff to resident neglect. The CI report indicated that resident #001 had been restrained. The CI report further indicated that a review of the video camera footage showed that the resident was restrained at an identified time, and was not repositioned until several hours later.

Inspector #736 reviewed resident #001's plan of care that was in effect at the time of the incident. The plan of care indicated that the resident could be restrained for a described period of time (no greater than 60 minutes). The Inspector also reviewed the doctor's order, that directed staff that resident #001 could be restrained for a described period of time (no greater than 60 minutes).

In an interview with Inspector #736, RN #104 indicated that resident #001 had a physician's order to be restrained for a described period of time (no greater than 60 minutes). The RN further indicated that, based on the video footage of the home area, the resident had remained restrained for a period greater than five hours. The RN

indicated that resident #001 was not provided care as per their plan of care, as the resident was restrained for longer than ordered and indicated.

In an interview with the DOC, they indicated that resident #001's plan of care directed staff to restrain the resident for a described period of time (no greater than 60 minutes), however, based on the home's investigation, the resident had remained restrained for approximately six hours. The DOC further indicated the resident was not provided with the care as set out in the plan of care, as they should have only remained restrained for a described period of time (no greater than 60 minutes) at a time. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The license has failed to ensure that the full report for an allegation of neglect was submitted to the Director within 10 days.

A CI report was submitted to the Director, related to an allegation of staff to resident neglect.

At the start of the inspection, 12 days after the home was made aware of the allegation of neglect towards resident #001, the CI report had not been updated or amended with the outcome of the investigation, immediate actions to prevent recurrence, or long term actions to prevent recurrence.

Inspector #736 reviewed the home's internal investigation notes related to the allegation of neglect of resident #001, that took place on an identified date. The home issued disciplinary action five days later, towards PSW #110 related to the incident. The Inspector was unable to locate any further documents in the investigation package after the identified date.

In an interview with the DOC, they indicated to the Inspector that it was their understanding that a CI report was to be updated within 10 days, or sooner if requested. The DOC indicated that the home had spoken with most staff involved, and that the CI would be updated within the "next few days". The DOC indicated that the CI should have been updated within 10 days to reflect the outcome of the investigation. [s. 104. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any unexpected death was immediately reported to the Director.

A CI report was submitted to the Director, for the unexpected death of resident #002. The CI report indicated that the Ministry of Long Term Care after hours pager had not been contacted.

A memo from the Director on December 18, 2018, reminded the Long Term Care Homes of the reporting requirements for an unexpected resident death.

In an interview with the Assistant Director of Care (ADOC), they indicated to Inspector #736, that both themselves and/or the DOC were responsible to submit CI reports to the Director, and that an unexpected death was to be reported to the Director immediately. The ADOC further indicated that they became aware the morning that resident #002 had passed away, however the home was unsure at the time, if the death was considered to be unexpected or not, therefore the report was submitted to the Director two days later. The ADOC also indicated that the death of resident #002 should have been immediately reported to the Director. [s. 107. (1) 2.]

WN #4: 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:

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:
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.) 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. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
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 saillants :

1. The licensee has failed to ensure that staff released the resident from the physical device and that the resident was repositioned at least once every two hours.

A CI report was submitted to the Director related to resident #001 being found restrained. Please see WN #1 for further details.

In an interview with PSW #110, they indicated to Inspector #736 that they had restrained

resident #001, however, they further indicated that they did not reposition the resident for the remainder of their shift.

In an interview with RN #104, they indicated to Inspector #736 that they noted resident #001 restrained at an identified time. The RN indicated that they reviewed the video footage of the home area, and did not note any time where staff had repositioned the resident.

A review of the home's policy titled "Restraint and Personal Assistance Services Device (PASDs) Policy and Procedure", policy #R.6.2.0, last revised June 14, 2019, indicated that the PSWs were responsible to release the restraint and reposition the resident every two hours, while a restraint was in use.

In an interview with the DOC, they indicated to the Inspector that they had completed an investigation into the allegation of neglect of resident #001. The DOC further indicated that based on the home's investigation, and review of the video cameras on the home area, resident #001 had been restrained for approximately six hours, without being repositioned. The DOC indicated to the Inspector that the resident should have been repositioned every two hours. [s. 110. (2) 4.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including the circumstances precipitating the application of the physical device, the person who applied the device and the time of application, and, all assessment, reassessment and monitoring, including the resident's response.

A CI report was submitted to the Director for resident #001, who had been restrained. Please see WN #1 for further details.

Inspector #736 reviewed the resident's plan of care, which indicated that the resident could be restrained for a described period of time (no greater than 60 minutes).

Inspector #736 reviewed the progress notes, as well as Point of Care (POC) documentation, for resident #001, and was not able to locate any documentation that indicated the circumstances which resulted in the resident requiring a restraint. The Inspector was unable to identify any documentation in the resident's health care record that indicated that when the restraint was applied and by whom. The Inspector was also unable to identify any documentation that indicated that the resident was assessed,

reassessed, or monitored for the use of the restraint, or the resident's response.

In an interview with the DOC, they indicated that staff were to document on the resident's electronic health record when the resident was restrained, as well as why the resident required the restraint, the assessment, reassessment and monitoring, as well as the resident's response. The DOC further indicated that in relation to resident #001, the staff had not documented that the resident required the restraint, the rationale, the assessment, reassessment and monitoring, as well as the resident's response, and should have. [s. 110. (7)]

Issued on this 19th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), AMANDA BELANGER (736)
Inspection No. / No de l'inspection :	2019_565647_0027
Log No. / No de registre :	018464-19, 020329-19, 021066-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 18, 2019
Licensee / Titulaire de permis :	The Board of Management for the District of Nipissing East 400 Olive Street, NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	Cassellholme 400 Olive Street, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To The Board of Management for the District of Nipissing East, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must:
a) ensure that the plan of care is provided for any residents relating to restraint use, and
b) ensure that the plan of care is provided for any residents relating to bed rail use.

Grounds / Motifs :

1. 1. The licensee 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 Critical Incident (CI) report was submitted to the Director for Improper/Incompetent treatment of resident #003 that resulted in harm or risk of harm.

A review of the CI report, by Inspector #647, identified that when Personal Support Worker (PSW) #102 started their shift, they entered the room of resident #003 and observed an identified device in use, resulting in the resident being entrapped. The PSW immediately contacted Registered Nurse (RN) #108 who completed an assessment that identified resident #003 sustaining an injury.

A record review of the resident's health care record including an assessment and electronic plan of care indicated the resident did not require the identified device.

In an interview with Inspector #647, Unit Coordinator (UC) #113 indicated that they initiated an investigation as to who was the responsible person that applied the device. The UC indicated to the Inspector, that through the investigation, they were unable to determine who was responsible, however did acknowledge that resident #003 was not to have it.

In an interview with the Director of Care (DOC), they indicated that the home's internal investigation indicated that the home did not provide care to resident #003 as specified in the plan of care when the device had been applied.

2. A CI report was submitted to the Director for an allegation of staff to resident neglect. The CI report indicated that resident #001 had been restrained. The CI report further indicated that a review of the video camera footage showed that the resident was restrained at an identified time, and was not repositioned until several hours later.

Inspector #736 reviewed resident #001's plan of care that was in effect at the time of the incident. The plan of care indicated that the resident could be restrained for a described period of time (no greater than 60 minutes). The Inspector also reviewed the doctor's order, that directed staff that resident #001 could be restrained for a described period of time (no greater than 60 minutes).

In an interview with Inspector #736, RN #104 indicated that resident #001 had a physician's order to be restrained for a described period of time (no greater than 60 minutes). The RN further indicated that, based on the video footage of the home area, the resident had remained restrained for a period greater than five hours. The RN indicated that resident #001 was not provided care as per their plan of care, as the resident was restrained for longer than ordered and indicated.

In an interview with the DOC, they indicated that resident #001's plan of care directed staff to restrain the resident for a described period of time (no greater than 60 minutes), however, based on the home's investigation, the resident had remained restrained for approximately six hours. The DOC further indicated the resident was not provided with the care as set out in the plan of care, as they should have only remained restrained for a described period of time (no greater than 60 minutes) at a time. [s. 6. (7)]

The severity of this issue was determined to be a level three, as there was actual harm or actual risk to the residents of the home. The scope of the issue was a level one, as it was identified to be an isolated issue. The home had a level three compliance history, as they had previous non-compliance with this section of the LTCHA. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

Service Area Office /
Bureau régional de services : Sudbury Service Area Office