Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2016	2015_376594_0030	032280-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Board of Management for the District of Parry Sound East
62 Big Bend Avenue Box 400 POWASSAN ON P0H 1Z0

Long-Term Care Home/Foyer de soins de longue durée

EASTHOLME HOME FOR THE AGED
62 BIG BEND AVENUE P.O. BOX 400 POWASSAN ON P0H 1Z0

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

MONIKA GRAY (594), LINDSAY DYRDA (575), MARIE LAFRAMBOISE (628)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 07-11 and 14, 2015.

This inspection included a complaint related to withholding approval for admission.

During the course of the inspection, the inspector(s) spoke with Residents, a Resident's Family/Substitute Decision Maker (SDM), Personal Support Workers (PSWs), Housekeepers, Activity Co-ordinator, Co-ordinator of Resident Services (CRS), Registered Practical Nurses (RPNs), Registered Nurses, Director of Administrative Services, Director of Support Services, Director of Nursing and Personal Care (DONPC) and the Administrator.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
0 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	Legendé 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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for the resident was provided to the resident as specified in the plan.

Resident #002’s plan of care documented that the resident required the use of a safety device.

On December 09, 10 and 11, 2015, Inspector #594 observed the resident with no safety device in use.

An interview was conducted with PSW #114 on December 11, 2015. They stated to the inspector that the resident did not require the use of a safety device.

An interview was conducted with RN #111 on December 11, 2015. They confirmed to the inspector that the resident required the use of a safety device and confirmed that the resident did not have a safety device in use. [s. 6. (7)]

2. 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.

On December 11, 2015, Inspector #575 observed a resident asking for help outside of a lounge near a nursing station. The resident reported that resident #014 was on the floor.

The inspector observed resident #014 on the floor.

Resident #014's plan of care was reviewed by the inspector which indicated that the resident was at risk for falls, and required a number of safety devices.

An interview was conducted with RPN #109 regarding the fall. RPN #109 indicated that the resident removed their safety device. The RPN confirmed that the resident did not have additional safety devices in place at the time of the fall and should have. [s. 6. (7)]

3. The licensee has failed to ensure that the 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.

Resident #001's plan of care documented that staff were to remove the wheelchair footrests to allow the resident to use their feet to mobilize their wheelchair.

On December 10, 11 and 14, 2015, the resident was observed seated in their wheelchair with the footrests in use.

An interview was conducted on December 11, 2015, with PSW #116 and RPN #117. PSW #116 stated that the resident used footrests and they had never observed the resident to be without them. RPN #117 indicated that the resident used the footrests when they were being assisted to and from the dining room in their wheelchair.

An interview was conducted on December 14, 2015, with RN #111. They stated that the resident no longer self-propelled their wheelchair and the plan of care should have been updated to reflect the need of foot rests. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for resident #002 and #014, the care set out in the plan of care related to their risk for falls, is provided to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (10) The persons referred to in subsection (9) are the following:
1. The applicant. 2007, c. 8, s. 44. (10).
2. The Director. 2007, c. 8, s. 44. (10).
3. The appropriate placement co-ordinator. 2007, c. 8, s. 44. (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee shall give to the Director and the appropriate placement co-ordinator a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval, and contact information for the Director.

Inspector #575 reviewed a complaint submitted to the Director related to the refusal of admission for client #012. The complainant stated that the home refused admission based on the home lacking the facilities necessary to provide a safe and secure environment.

The inspector conducted an interview with the DONPC and the Coordinator of Resident Services (CRS) regarding the admission refusal for this client. They stated that once applications are reviewed by the home, the CRS would respond to the Community Care Access Centre (CCAC) via the online program Health Partner Gateway (HPG) and a letter would be sent out to the client and/or family, and to the Director.

The inspector requested a copy of the refusal letter sent to this client, however the home was not able to provide a copy as the CRS indicated they are not required to keep records of the refusal letters sent out.

The inspector confirmed that the Director did not receive a refusal letter from the home.

A staff member at the CCAC advised the inspector that they did not have a refusal letter on file. [s. 44. (10)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that complied with manufacturer's instructions for the storage of the drugs.

On December 14, 2015, Inspector #594 and RN #111 observed a Medication Storage Room and identified a medication with an expiry date of November 30, 2015.

RN #111 confirmed to the inspector that the medication was past the expiry date. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On December 14, 2015, Inspector #594 and RN #111 observed a Medication Storage Room. Controlled substances were stored in a single locked drawer within the locked area.

Inspector #594 and the Director of Nursing and Personal Care (DONPC) observed the same medication storage room and confirmed that controlled substances were stored in a single locked drawer within the locked area. [s. 129. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On December 14, 2015, Inspector #594 observed RPN #118 conduct a medication pass. The inspector observed the RPN administer medication to nine residents and they did not perform any hand hygiene before, during or after administration of medications. During the medication pass, RPN #118 was observed to hug a resident and hold their hand, during that same medication pass RPN #118 was observed to open a medication capsule to dispense the contents into a cup without performing hand hygiene before or after administration.

Inspector #575 reviewed the home's policy titled 'Hand Hygiene Program' effective October 2014. The policy stated that the home adopted the Just Clean Your Hands program for long term care homes and that staff should follow the four moments of hand hygiene, including but not limited to before initial patient/patient environment contact and after patient/patient environment contact

On the same day, an interview was conducted with the DONPC who confirmed that staff were required to complete hand hygiene before and after medication administration to each resident. [s. 229. (4)]

Issued on this 20th day of January, 2016

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

Original report signed by the inspector.