Ontario

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 7, 2017	2017_638609_0014	002652-17	Complaint

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 26-30, 2017.

This inspection was conducted as a result of: One complaint submitted to the Director related to the care resident #001 received in the home.

A Critical Incident inspection #2017_638609_0015 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Physicians, Director of Nursing (DON), Director of Administrative Services, Nursing Administrative Assistant (AA), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family of residents.

The inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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

- **1 WN(s)**
- **0 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A Complaint was submitted to the Director which alleged that the home did not act on information that resident #001's weight had changed since admission.

Inspector #609 reviewed resident #001's health care records which documented the resident's weight taken on admission by the home on a particular day was a specific weight. This specific weight was again documented one week later.

A review of resident #001's progress notes found between a specified period of time (approximately one month later), seven entries related to a medical condition which had the potential to alter the resident's weight.

A progress note on a particular day during the specified period of time, found registered staff indicated that resident #001 was weighed twice that day and had appeared to have a significant change in weight. Registered staff questioned whether the resident's admission weight was accurate.

In a progress note, registered staff indicated that resident #001 was reweighed several times over the last couple of days and their weight had significantly changed from the resident's admission weight. Rather than rely on the weights previously obtained by the home, registered staff used the Community Care Access Centre (CCAC) admission package weight to conclude that the resident had not significantly changed weight. The progress note further indicated that the Registered Dietitian (RD) was to be notified of their findings.

a) A review of the home's policy titled "Criteria for Referral to Dietitian" last reviewed February 2017 directed staff to, in a timely and effective manner, notify the RD of all changes in the status of a resident which included edema and significant weight changes.

During an interview with the RD they indicated that they were to be notified of any significant changes in a resident's weight and denied any referral or notification of any kind was made to them related to resident #001's possible edema or change in weight.

b) During an interview with the RD a review of resident #001's health care records was conducted. They indicated that an initial dietitian assessment was completed. At that time the RD investigated why there was significant weight difference between admission to the home and the CCAC's admission package weight. The RD was informed by the family that the resident had changed weight while in hospital. The RD verified that they were satisfied with the response from family, that the resident had changed weight and based their assessment of the resident on the home's admission weight and not the CCAC weight.

A review of the resident #001's health care records found in a progress note that physician #120 indicated that the resident's admission weight was an error and that the accompanying CCAC admission package weight was accurate.

During an interview with physician #120 they verified that despite questions related to the accuracy of resident #001's weight, there was no consultation with the RD or the RD assessment before making the decision that the home's admission weight was wrong. [s. 6. (4) (a)]

Issued on this 10th day of August, 2017

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

Original report signed by the inspector.