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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 10, 2017 | 2017_638609_0016 | 013667-17 | 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. BOX400 POWASSAN ON P0H 1Z0

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

CHAD CAMPS (609), RYAN GOODMURPHY (638)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 10-14, 2017.**

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

**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, internal investigations, policies, procedures, programs, and program evaluation records.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Residents' Council**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**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 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.

During the course of the inspection resident #002 was identified as having increased intensity of pain between the last and most recent uploaded Minimum Data Set (MDS).

Inspector #609 reviewed resident #002's current plan of care which indicated that the resident required an identified intervention be applied for a specified condition the resident had.

On July 12 and 13, 2017, resident #002 was observed several times throughout each day without the identified intervention applied.

a) A review of the home's policy titled "Care plans and Plans of Care" last reviewed June 2017 indicated that the care plan would be reviewed and revised using an interdisciplinary team approach when the care set out in the plan was no longer effective.

During interviews with PSW #103 and RPN #104 they verified that resident #002 was to have the identified intervention applied for a specified condition the resident had. They also verified that the intervention was not an effective intervention as the resident often unapplied the intervention.

Neither PSW #103 nor RPN #104 were able to indicate that physiotherapy was to be referred to when an intervention was assessed as ineffective.

During an interview with the DON they indicated that the home's process was for staff to complete a paper requisition for physiotherapy when their service was required and should have occurred when resident #002's identified intervention was found to not be effective by registered staff.

During an interview with the DON they indicated that there was a gap in the home's written procedure related to when and who was to make referrals to physiotherapy. This would have ensured that the interdisciplinary team collaborated when the plan was no longer effective.

b) A review of the home's policy titled "Care plans and Plans of Care" last reviewed June 2017 indicated that the care plan would be reviewed and revised using an interdisciplinary team approach when a goal in the plan was met.

A review of resident #002's health care records found that on a particular day, Physiotherapist #112 had assessed the resident. The resident was found that physiotherapy had been effective in preventing the specified condition.

During an interview with Physiotherapist #112 they verified that the physiotherapy provided to resident #002 had been effective in preventing a worsening of the resident's specified condition and that the resident no longer required the identified intervention.

Physiotherapist #112 indicated that after they had assessed resident #002's therapy to be effective in preventing a worsening of the resident's specified condition, they should have collaborated with the registered staff to ensure that their plans of care were integrated. This would have ensured that the identified intervention was removed from the resident's plan of care when the goal was met. [s. 6. (4) (a)]

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.

During the course of the inspection resident #008 was identified as having increased intensity of pain between the last and most recent uploaded MDS.

During an interview with Inspector #609 resident #008 indicated that they were acutely experiencing pain. The resident also indicated that any movement caused increased pain.

The "Pain Management" policy also indicated that staff were to follow the interventions as outlined in the resident's plan of care.

A review of resident #008's plan of care indicated that staff were to ensure pain was managed by providing an identified intervention prior to getting up.

During an interview with RPN #109 they verified that resident #008 had no scheduled identified intervention. The RPN also verified that there was no prompt to alert registered staff to provide resident #008 with the specified intervention before getting them up.

A review of resident #008's health care records for a 30 day period found 17 progress note entries that indicated that the resident was transferred out of bed.

A review of resident #008's corresponding MAR found that in all 17 instances, the resident was not provided the specified intervention prior to being transferred out of bed. [s. 6. (7)]

3. During the course of the inspection, Inspector #638 observed resident #001 seated in their mobility aid with a specified device applied on two separate days.

A review of resident #001's plan of care was unable to identify any indication that the resident required the use of the specified device while in their mobility aid. The Inspector was unable to locate any completed assessments or orders identifying that the resident required the use of the specified device.

A review of the home's policy titled "Care Plans and Plans of Care" last reviewed June 2017 indicated that the plan of care would provide direction to staff to meet the needs of each resident in a consistent manner.

A review of resident #001's health care records found in a progress note that on a particular day RPN #105 applied the specified device to the resident's mobility aid.

During an interview with RPN #105 they verified that resident #001 did not require the specified device and that they did not review resident #001's plan of care prior to

applying the device to the resident's mobility aid.

During an interview with the DON they verified that RPN #105 did not provide resident #001 with care as specified in the plan of care when they applied the specified device to the resident's mobility aid. [s. 6. (7)]

***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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other as well as ensure that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During the course of the inspection resident #008 was identified as having increased intensity of pain between the last and most recent uploaded MDS.

During an interview with Inspector #609 resident #008 indicated that they were acutely experiencing pain. The resident also indicated that any movement caused increased pain.

a) A review of the home's policy titled "Pain Management" effective date August 2011 indicated that an interdisciplinary pain assessment was to be completed when a resident was taking Pro Re Nata (PRN) or as needed, pain-related medications for greater than 72 hours or when a resident had distress related behaviours.

During an interview with RPN #109 a review of resident #008's MAR was conducted. RPN #109 was unable to tell the inspector that an interdisciplinary pain assessment was to be conducted when a resident was using pain-related medications for greater than 72 hours or when the resident had distress related behaviours.

A review of resident #008's health care records for the 30 day period found multiple progress note entries related to the resident exhibiting responsive behaviours or complaining of pain.

A review of resident #008's Medication Administration Record (MAR) for the 30 day period found the resident was administered PRN medication for pain or responsive behaviours multiple times.

During an interview with the DON they stated that staff did not follow the home's "Pain Management" policy when resident #008 was not reassessed when multiple PRN doses of pain or responsive behaviour medication was administered to the resident in the review period.

b) The policy further indicated that registered staff were to collaborate with the interdisciplinary team in the assessment of pain.

During an interview with the Pharmacist they indicated that registered staff should have made them aware of resident #008's PRN medication usage as well as continued responsive behaviours in order to have the resident reassessed on their weekly interdisciplinary rounds. [s. 8. (1) (a),s. 8. (1) (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 staff comply with the home's "Pain Management" policy, to be implemented voluntarily.***

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**Issued on this 11th day of August, 2017**

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

**Original report signed by the inspector.**