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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2018	2018_671684_0031	015042-17, 015565-17, 022744-17, 006056-18, 006576-18, 014690-18, 015017-18, 022184-18, 022903-18, 024688-18	Critical Incident System

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

SHELLEY MURPHY (684), CHAD CAMPS (609)

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): December 10-14, 2018.

The following intakes were inspected during this Critical Incident Inspection:

Three logs related to responsive behaviours;

One log related to falls prevention;

One log related to improper care of a resident;

One log related to alleged staff to resident abuse;

One log related to disease outbreak,

One log related to alleged visitor to resident sexual abuse, and;

Three logs related to resident to resident alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager/Previous Acting Administrator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also conducted daily tours of the resident care areas, observed provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, internal investigation files, human resource files and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **5 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	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).

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 was provided to the resident as specified in the plan.

Inspector #684 reviewed a Critical Incident (CI) report which was submitted to the Director on a specified date in 2018, for improper/incompetent treatment of a resident; which resulted in harm or risk to a resident. The CI report indicated that resident #003 sustained an injury while PSW #110 was providing care to them.

Inspector #684 asked PSW #110 about the CI report the home had submitted to the Ministry of Health and Long-Term Care. PSW #110 stated that they knew resident #003's intervention for transferring but did not know their intervention for bed mobility. PSW #110 then stated that while they were providing care to resident #003, the resident sustained an injury. PSW #110 stated that they tried to prevent resident #003 from sustaining an injury.

Inspector #684 interviewed PSW #111 who stated that resident #003 required a specific intervention for bed mobility care. The Inspector asked PSW #111 where they would find information on bed mobility, and they indicated in the care plan, kardex and in the resident's closet.

Inspector #684 reviewed resident #003's care plan, kardex and information sheet in the

closet, which indicated that resident #003 had a specific intervention for bed mobility.

Inspector #684 reviewed the home's policy titled "Care Plan" last updated December 2018, which stated under the purpose: "To provide direction to staff to meet the needs of each resident in a consistent manner."

Inspector #684 reviewed a discipline letter written by the DOC which stated that PSW #110 confirmed they did not follow the care plan and interventions identified for bed mobility for resident #003. The discipline letter was signed by PSW #110.

Inspector #684 interviewed the DOC about where staff would find information on bed mobility for a resident, to which the DOC replied in the resident care plan. Inspector #684 then asked if it was the expectation that staff follow the care plan when providing care to residents, and the DOC replied "absolutely". The DOC confirmed that PSW #110 did not follow the resident's care plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Two CI reports were submitted by the home to the Director which outlined allegations of resident to resident sexual abuse on two separate dates, towards resident #007 by resident #006.

Inspector #609 reviewed resident #006's health care records and found that on a specified date, the resident was observed inappropriately touching and making comments to resident #007.

Health care records were reviewed and noted that on a specified date that inappropriate behaviour was observed between resident #007 and resident #006.

A review of resident #007's current plan of care required staff to follow a specific intervention to deter co-residents from entering their room.

On a specified date, resident #007 was observed by Inspector #609 in their room and the intervention which was identified in the resident care plan was not in place at the time of the observation. A note was visible which stated the intervention was to be used when resident #007 was in their room.

During an interview with PSW #105, they indicated that resident #006's condition had changed and they no longer sought out resident #007 and, as a result the intervention for resident #006 was no longer required when they were in their room.

During an interview with RPN #104, resident #006's progress note was reviewed. The RPN indicated that they no longer needed to use the identified intervention as resident #006 and #007 no longer sought each other out.

A review of the home's policy titled "Care Plans and Plans of Care" last revised December 2018, required the resident's care plan to be reviewed and revised when the resident's care needs changed.

During an interview with the DOC, they stated "yes" when asked if it was the expectation of the home that a resident's plan of care was reviewed and revised when the resident's care needs changed. [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 that ensures the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero

tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director on a specified date in 2018, which outlined allegations of emotional abuse of resident #004 by PSW #115.

Inspector #609 reviewed resident #004's health care record and found no documentation of the incident.

a) During an interview with PSW #113, they described how on a specified date in 2018, PSW #115 was in a specified area with resident #004 and observed resident #004 exhibiting a behaviour. PSW #115 was inappropriate in their actions and response towards resident #004 and their exhibited behaviour.

PSW #113 described how they immediately intervened and separated PSW #115 from resident #004 and notified RPN #116 about the incident.

A review of the home's policy titled "Zero Tolerance of Abuse, notification Re Incident, Police Notification and Evaluation" last revised June 2018, indicated that the home was committed to a zero tolerance of abuse or neglect of residents. The policy further indicated that emotional abuse was considered as any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

During an interview with the DOC, they verified that they had conducted an internal investigation of the incident and verified that PSW #115 was inappropriate in their interaction with resident #004. The DOC stated, "yes" when asked if it was the expectation of the home that residents were to be free from abuse and neglect.

A review of PSW #115's letter of discipline from a specified date in 2018, indicated that they were inappropriate to residents. As a result, PSW #115 received disciplinary action and retraining on the home's abuse policy.

b) A further review of the CI report indicated that the allegations of abuse towards resident #004 by PSW #115 had occurred on a specified date 2018, but was only reported to the DOC a number of days later when PSW #113 told the DOC. This was despite RN #114 being made aware of the allegations on the initial date in 2018, by RPN #116.

A review of the home's policy titled "Zero Tolerance of Abuse, notification Re Incident, Police Notification and Evaluation" last revised June 2018, required registered staff who received a report of alleged, witnessed or unwitnessed abuse or neglect, was to immediately notify the Administrator/Director of Nursing and Personal Care or designate.

During an interview with RN #114, they indicated that on a specified date in 2018, RPN #116 notified them of the incident between PSW #115 and resident #004. The RN acknowledged that they should have immediately reported the incident to a member of the home's management team.

During an interview with the DOC, they verified that RN #114 should have immediately informed them of the incident; as a result, RN #114 received retraining on the home's abuse and mandatory reporting policies. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

Inspector #684 reviewed a CI report which was submitted to the Director on a specified date in 2018, and for which the After Hours Info Line was contacted one day earlier related to the improper/Incompetent treatment of resident #003 that resulted in harm or risk to the resident. The CI report indicated that the incident occurred one day prior to the After Hours Info line being contacted and two days prior to the CI report submission to the Director. Please refer to WN #1, Part 1 for additional details.

The Inspector reviewed the resident's progress notes and identified a specific type of investigation note written on a specified date in 2018, regarding the incident which lead to the CI report submission.

Inspector #684 interviewed RN #109 who stated; should an incident occur where a resident received improper care that resulted in harm due to staff not following the care plan this would be reported immediately to the Ministry of Health and Long-Term Care.

Inspector #684 reviewed the CI amended report which stated RN #112 received disciplinary action regarding not following procedure and reporting this incident to after hours pager.

Inspector #684 reviewed the home's policy titled "Critical Incident" last reviewed June 20, 2018, which stated under "Reporting Certain Matters to the Director- Mandatory Reporting- improper of incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident. Reporting time frame-immediately upon becoming aware of the incident."

During an interview with the DOC they indicated to Inspector #684 that should a resident receive improper or incompetent treatment or care that resulted in harm or a risk of harm, this would be immediate reporting. Inspector #684 and the DOC reviewed the CI report that was submitted to the Director as well as the After Hours Info line report which was submitted to the Ministry of Health and Long-Term Care, the DOC agreed this was late reporting. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, including wandering; any identified responsive behaviours; and any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted by the home to the Director on a specific day in 2018, which outlined how resident #004 and PSW #115 had a altercation when PSW #115 was inappropriate in their actions and response towards resident #004's exhibited behaviour.

Inspector #609 reviewed resident #004's health care record and found a progress note which indicated that the resident was observed exhibiting a behaviour. When the PSW addressed the behaviour the resident exhibited further responsive behaviours.

During an interview with PSW #111 and RPN #104, they indicated that resident #004 had responsive behaviours to a specific staff action.

A review of resident #004's plan of care failed to mention the behaviour or their triggers to a specific staff action.

A review of the home's policy titled "Care Plans and Plans of Care" last revised December 2018 required the resident's plan of care be based on an interdisciplinary assessment of their mood and behaviour patterns, including wandering, any identified responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of the day.

During an interview with the DOC, they described how they had previously spoken with the resident's Substitute Decision Maker (SDM) and together agreed on a plan related to the resident's behaviours specific to a staff action.

A review of resident #004's plan of care was conducted with the DOC who acknowledged resident #004's specific action was an identified behaviour. Further, that a specific staff action was a potential trigger for the resident's responsive behaviours and should have been reviewed in the resident's plan of care. [s. 26. (3) 5.]

WN #5: 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):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

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

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incident in the home, followed by the report required under subsection (4): An outbreak of a reportable disease or communicable disease as defined the the Health Protection and Promotion Act.

Inspector #684 reviewed a CI report which was submitted to the Director on a specified date in 2018, related to disease outbreak. The CI report stated the onset of the outbreak was a specific date in 2018.

Inspector #684 reviewed a letter from North Bay Parry Sound Health Unit which indicated "On [a specific date in 2018], an outbreak was officially declared at your facility and outbreak control measures were implemented."

During an interview with RN #109 they indicated to Inspector #684 that when an outbreak was declared they would immediately report this to the Ministry of Health and Long-Term Care.

Inspector #684 reviewed home policy titled "Critical Incident" last reviewed June 20, 2018. Within the section "Notifications Regarding Incidents under procedure it states "The Director MOHLTC is immediately informed of each following incidents of the home- followed by the completed online report. An outbreak of a reportable disease or communicable disease as defined by the Health Protection and Promotion Act."

Inspector #684 interviewed the Infection Control Lead/DOC who informed Inspector #684 that they would report an outbreak to the Ministry of Health and Long-Term Care as soon as the outbreak was declared by the Public Health Unit. A review of the CI report was conducted by both Inspector #684 and the Infection Control Lead/DOC; upon completion of the review the Infection Control Lead/DOC confirmed that the outbreak CI report was submitted late to the Ministry of Heath and Long-Term Care. [s. 107. (1)]

Issued on this 2nd day of January, 2019

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

Original report signed by the inspector.