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

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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
Aug 20, 2019	2019_565647_0020	005505-19, 006317-19, 014213-19	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. Box400 POWASSAN ON P0H 1Z0

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

JENNIFER BROWN (647)

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): August 13 - 16, 2019.

The following intakes were completed during the course of this Critical Incident System (CIS) inspection:
-Two intakes related to resident to resident abuse, and
-One intake related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Support Services, Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Outreach (BSO) Therapist, 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 training documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, was immediately reported to the Director.

A CI report had been submitted to the Director, related to an allegation of abuse or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident that occurred two days prior to the report to the Director.

A review of the CI report indicated that when the identified staff started their shift, resident #003 had been found in a compromised state.

During an interview with Personal Support Worker (PSW) #107, they indicated that when they had found resident #003 in a compromised state, they provided assistance to the resident. PSW #107 further indicated that after resident #003 received the assistance they required, they reported their findings to the Director of Care (DOC).

Inspector #647 reviewed the licensee's policy titled, "Zero Tolerance of Abuse, Notification of incident, Police Notification and Evaluation", Volume 8, Section 4.0, Z.1, dated August 2019. The policy indicated that "a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it was based to the Director".

Additional information related to the reporting requirements had been sent to all Long-Term Care home licensees on July 5, 2018, from the Director. The memo titled "Clarification of Mandatory and Critical Incident Reporting Requirements" further clarified that the Director shall be immediately informed of the suspicion of abuse by anyone or neglect of a resident by the licensee or staff.

During an interview with the DOC, they indicated that they became aware of the incident the same day that it had occurred, and commenced an investigation, however did not immediately inform the Director.

During a further interview with the DOC they indicated that they did not submit the CI report until two days after they were aware of the incident, and acknowledged that the CI report was not submitted to the Director as per the required legislation. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

A CI report was submitted to the Director, for abuse of a resident by anyone or neglect by the licensee or staff that resulted in harm or risk of harm to resident #003 during an identified shift.

A review of the CI report indicated that, when the staff started their shift, resident #003 had been found to be in a compromised state, that also included a saturated incontinent product and saturated bed linens.

During an interview with PSW #107, they indicated that when they arrived for their shift, they were called into resident #003's room by two other co-workers. PSW #107, explained to the Inspector, that when they arrived to the room, they could smell a strong odor of ammonia. PSW #107 further indicated that, resident #003 was in a compromised state, the linens were soaked with urine and felt cool to touch, and the incontinent product was filled to capacity with urine. PSW #107, reported that the three PSW's proceeded to wash resident #003, change their bed linen and dress them in dry clothing.

A review of resident #003's electronic plan of care indicated that the resident was totally incontinent and staff were to check or change their incontinent brief during every nursing round.

In an interview with Inspector #647, PSW #108 indicated that they were working on the identified shift, and was responsible for resident #003's care. PSW #108 indicated that there was a shift routine form that directed staff on their duties during their shift. This shift routine indicated that staff were to change and reposition residents as required at an identified time; visualize residents for safety at an identified time; and change and reposition residents as required at an identified time. PSW #108 acknowledged during the interview that they checked resident #108 for safety however had not checked the status of their incontinent product during the shift, and that they should have to ensure resident #003 remained clean, dry and comfortable.

In an interview with the DOC, they indicated that the home's internal investigation concluded that PSW #108 had not completed incontinent rounds on resident #003, and as a result, resident #003 had been found with a saturated incontinent product, and soaked bed linens. [s. 51. (2) (g)]

Issued on this 21st day of August, 2019

[redacted]

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

Original report signed by the inspector.