Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 20, 2019	2019_657681_0031	021291-19	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. Box 400 POWASSAN ON P0H 1Z0

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

STEPHANIE DONI (681)

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 2 - 6, 2019.

One intake, related to an allegation of staff to resident neglect, was inspected during this Critical Incident inspection.

A Sudbury Service Area Office initiated inspection, #2019_657681_0030, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Nursing Administrative Assistant, Personal Support Workers (PSWs), and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, and home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #001.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that PSW #109 was transferring resident #001 with a specified device when the resident fell and sustained an injury.

During an interview with PSW #109, they stated that they were transferring resident #001 using a specified device when the resident fell. PSW #109 acknowledged that they were not following correct procedure when transferring the resident and that a second staff member was not present during the transfer.

The Inspector reviewed a disciplinary notice for PSW #109, which indicated that the PSW received disciplinary action related to the incident because the PSW's actions were in breach of the home's policies and procedures.

During an interview with the DOC, they stated that, through the home's investigation, it was determined that PSW #109 did not follow appropriate procedures related to the safe transferring of residents. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care set out clear directions to staff and others who provided direct care to the resident.

A CIS report was submitted to the Director related to an allegation of staff to resident neglect. Refer to WN #1 for further details.

Inspector #681 reviewed resident #001's care plan, which indicated that resident #001 was to receive a specified bathing method.

The Inspector reviewed the Bath List for a specified unit, which identified that resident #001 was to receive a different specified bathing method.

During separate interviews with PSW #109 and PSW #116, they stated that resident #001 was receiving the bathing method identified on the unit's Bath List.

During an interview with RN #107, they stated that resident #001 was receiving the bathing method identified on the unit's Bath List. RN #107 acknowledged that the Bath List identified that the resident was to receive a specified bathing method, but the resident's care plan identified a different specified bathing method.

During an interview with the DOC, they stated that bath lists and care plans were both part of a resident's plan of care and that documents within the plan of care should be consistent and not provide conflicting information to staff. [s. 6. (1) (c)]

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.