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
Jul 2, 2021	2021_668543_0017	009029-21	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

TIFFANY BOUCHER (543)

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 10 & 11, and 14 & 15, 2021.

The following intake was inspected during this Complaint inspection:

-one intake, related to alleged abuse.

A Critical Incident inspection, was also conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Assistant Administrator/Environmental Service Manager, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW), family of residents and residents.

The Inspector also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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	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 a 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 to the resident, was immediately reported to the Director.

A complaint was submitted to the Director related to alleged abuse towards a resident that resulted in injury.

The Inspector reviewed a resident's electronic progress notes from a specific date in 2021. The progress note indicated that from an assessment that was completed, there was alleged concerns related to a form abuse. A subsequent progress note also identified that there were concerns related to potential abuse.

The Inspector reviewed the Zero Tolerance of Abuse, notification re: Incident, Police Notification and evaluation policy. The policy indicated that Registered staff would notify the Administrator/Director of Nursing and Personal Care or designate immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse or neglect, and initiate the investigation. The Director of Nursing and Personal Care/Administrator would ensure an investigation and reporting process was underway by the staff member to whom the alleged abuse or neglect was reported as well as, initiate reporting to the MOHLTC.

In an interview with the DOC and ADOC, they verified that there were allegations of abuse, and indicated that they had the physician complete an examination related to the abuse allegations. The DOC and ADOC verified that the allegations were not immediately reported to the Director.

Sources: complaint intake, a resident's electronic progress notes, internal investigation documents, Zero Tolerance of Abuse, notification re Incident, Police Notification and evaluation policy and interview with the DOC and ADOC. [s. 24. (1)]

Issued on this 28th day of July, 2021

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

Original report signed by the inspector.