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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 25, 2021 | 2021_895609_0002 | 010002-21 | 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

KAREN HILL (704609)

## 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): October 18 - 20, 2021.**

**The following intake was inspected upon during this Critical Incident System inspection:**
**-one log related to improper care provided to a resident.**

**Inspector #681 had observed this CIS inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Nursing (ADON) and Infection Prevention and Control (IPAC) Lead, Food and Nutrition Manager, Environmental Services Supervisor, COVID-19 Screener, Registered Practical Nurses (RPNs), Nursing Aides, Orderlies, Housekeepers, Dietary Aides, Recreation staff, and residents.**

**The inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed staff and residents Infection Prevention and Control (IPAC) practices, reviewed relevant resident health records, staffing schedules, and the home's procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Infection Prevention and Control**
**Nutrition and Hydration**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 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 | Légende<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. (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 a resident was provided with the nutrition interventions that were set out in the resident's plan of care.

The resident's plan of care at the time of the incident, indicated that the resident was required to have a specific nutrition intervention. During the meal service, the resident received a nutrition intervention that was not ordered for that resident.

In an interview with the Food and Nutrition Manager, they verified the nutrition interventions in the resident's plan of care were known, and that the resident was provided with a nutrition intervention that was not appropriate.

Sources: Record review, interviews with staff member and Food and Nutrition Manager. [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 the care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.***

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**Issued on this 26th day of October, 2021**

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

**Original report signed by the inspector.**