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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2014	2014_336580_0022	S-000572-14	Resident Quality Inspection

Licensee/Titulaire de permis

EAST DISTRICT OF PARRY SOUND HOME FOR THE AGED
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

VALA MONESTIMEBELTER (580), FRANCA MCMILLAN (544), LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 20, 21, 22, 23, 24, 27, 28 and 29, 2014

The following log was completed as part of the RQI inspection: Log # 004229-14.

During the course of the inspection, the inspector(s) spoke with residents and their families, the President of the Family Council (PFC), the Administrator, the Director of Nursing and Personal Care (DON), Registered Nurses (RN) Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Coordinator of Resident Services and Staff Responsible to Family Council (CRS), the Director of Support Services (DSS), Housekeeping/Laundry Aides (HLAs), the Director of Recreation and Therapy Services (DRTS), the Activity Coordinator (AC), the Physiotherapist (PT), the Physiotherapy Assistant (PA), the Registered Dietitian (RD), Dietary Aides (DAs) and the Director of Administrative Services (DAS).

During the course of the inspection, the inspector(s) observed the provision of care and services to the residents, observed the dining and meal services, observed staff to resident interactions, reviewed the health care records of several residents and reviewed numerous policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (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).

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. On October 23, 2014, Inspector #575 reviewed resident #7685's health care record regarding continence care. The inspector noted that the care plan indicated that incontinence products are supplied per Attends List and that the resident uses pull-ups every shift. On October 27, 2014, staff #101 showed the inspector the current Attends List dated October 8, 2014. The Attends List indicated that the resident was to use a regular brief during days and evenings and a large night brief at night. The inspector showed the care plan and Attends List to the DOC who told the inspector that the care plan and Attends List contradicted each other. The DOC later told the inspector that the Attends List was correct and the care plan was updated.

The licensee failed to ensure that the plan of care for resident #7685 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #575 reviewed resident #3800's health care record regarding oral care. The inspector noted that the resident's most recent care plan indicated that the resident requires extensive total assistance and is to receive oral hygiene after meals to include cleaning of teeth after each meal, rinsing mouth and checking for any obvious deterioration of teeth and gums. The inspector interviewed two staff members regarding resident #3800's oral care. Staff #103 told the inspector that the resident would receive oral care every morning and evening. Staff #104 told the inspector that the resident receives oral hygiene care usually before or after breakfast and after supper - twice per day. The inspector asked the staff member if the resident receives oral hygiene after every meal and the staff member stated 'no, not normally'. The staff member confirmed they would review the resident's care plan for information on the resident's care needs.

The licensee failed to ensure that the oral hygiene care set out in the plan of care was provided to resident #3800 as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On October 20, 2014, at approximately 10:50 am, Inspectors #580 and #544 did the initial tour of the home and observed in one of the shower/tub areas: an unlabelled used nail clipper, 5 unlabelled deodorants (3 used), 1 unlabelled used lipstick, 1 unlabelled used jar of Infazinc, 1 unlabelled used hairbrush and 1 used unlabelled bar of soap; and in one of the shower/tub areas:12 unlabelled deodorant (4 used), 10 unlabelled jar of Infazinc (2 used), 3 unlabelled used soap, 1 used unlabelled comb, 1 unlabelled used hairbrush, and 1 unlabelled used foot scrub brush.

The licensee failed to ensure that each resident of the home has his or her personal items labelled. [s. 37. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. Inspector #544 reviewed a concern brought forward in the March 26, 2014, Family Council meeting minutes, regarding who was going to fill the bird feeders. The meeting minutes read: "This project isn't working out as we had planned and it will have to be looked at further." Inspector #544 could find no response or documentation in the meeting minutes held April 30, 2014, and May 28, 2014, that the licensee responded in writing within ten (10) days regarding this matter.

On April 30, 2014, in the Family Council meeting minutes it is written, "We talked about finding someone to volunteer to help residents with Skype, but do not know if there is a need at the present time." Inspector #544 could find no response or documentation in the meeting minutes held May 28, 2014, that the licensee responded in writing within ten (10) days regarding this matter.

Inspector #544 interviewed the Family Council President who confirmed that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. Inspector #544 interviewed Coordinator of Resident Services who is also the Staff Representative to Family Council and confirmed that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. Inspector #544 interviewed Administrator of the home and confirmed that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The licensee failed to ensure that the licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations. [s. 60. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Resident #5182 has a tilt chair and seat belt restraint ordered by the Physician and consent given by the Substitute Decision Maker (SDM). There were Restraint Monitoring Record sheets for resident #5182, in a binder, on the resident's home unit.

Inspector #544 reviewed the Home's Restraint Monitoring Record for resident #5182 for September 2014 and October 2014, and identified that the Restraint Monitoring Record documentation was incomplete according to the Home's codes and monitoring system regarding restraints. There were many hours in the 24 hour/day where there was no documentation in regards to the application, removal, observation and monitoring of resident #5182's restraints. There were hours that were blank and not initialled by staff according to the codes provided on the Restraint Monitoring Record.

Inspector #544 interviewed staff #108, the RAI/MDS Co-ordinator and showed them the Restraint Monitoring Records for resident #5182 for September and October 2014. Staff #108 confirmed that the documentation on the Restraint Monitoring Records, in regards to monitoring of resident #5182's restraints, were incomplete and not coded as staff were directed.

Inspector #544 interviewed staff #105 and staff #106 who both confirmed that the documentation on the Restraint Monitoring Records, in regards to monitoring of resident #5182's restraints for September 2014 and October 2014, were incomplete and not coded as staff were directed.

The licensee failed to ensure that the documentation in regards to restraints included all monitoring, including the resident's response. [s. 110. (7) 6.]

2. Resident #9232 has a tilt chair and seat belt restraint ordered by the Physician and consent given by the Substitute Decision Maker (SDM). There were Restraint Monitoring Record sheets for resident #9232, in a binder, on the resident's home unit.

Inspector #544 reviewed the home's Restraint Monitoring Record for resident #9232 for September 2014 and October 2014, and identified that the Restraint Monitoring Record documentation was incomplete according to the codes and monitoring system regarding restraints. There were many hours in the 24 hour/day where there was no documentation in regards to resident #9232's application, removal, observation and monitoring of their restraints. There were hours that were blank and not initialled by staff according to the codes provided on the Restraint Monitoring Record.

Inspector #544 interviewed staff #108, the RAI/MDS Co-ordinator and was shown the Restraint Monitoring Records for resident #9232 for September and October 2014. Staff #108 confirmed that the documentation on the Restraint Monitoring Records, in regards to monitoring of resident #9232's restraints, were incomplete and not coded as staff were directed.

Inspector #544 interviewed staff #105 and staff #106 who both confirmed that the documentation on the Restraint Monitoring Records, in regards to monitoring of Resident 9232's restraints for September 2014 and October 2014, were incomplete and not coded as staff were directed.

The licensee failed to ensure that the documentation in regards to restraints included all monitoring, including the resident's response. [s. 110. (7) 6.]

3. Inspector #575 reviewed resident #3800's health care record regarding the use of restraints. The inspector noted that resident #3800 had a seat belt restraint ordered by the physician 'when in wheelchair for safety and positioning' and consent was given by the resident's SDM. Inspector #575 reviewed the home's 'Restraint Monitoring Record' for resident #3800 from September 1 to October 26, 2014 and identified that the daily documentation was missing in regards to application, removal, monitoring, repositioning and resident response. Hourly documentation was not completed when the resident's restraint was applied. There were hours that were blank and not initialled by staff according to the codes provided on the home's 'Restraint Monitoring Record'.
Inspector #575 confirmed with staff #102 that the documentation on the 'Restraint Monitoring Records' were incomplete and not coded as staff were directed. The DOC also confirmed that staff are to record on the 'Restraint Monitoring Record' every hour when the resident's restraint is in place.

The licensee failed to ensure that the documentation in regards to restraints included all assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. During the initial tour on October 20, 2014 Inspector #544 observed the following:
- 6 Vitarub topical ointment jars, unlabelled, in an unlocked cupboard in the Therapy room on the South 3rd floor;
- 4 Vitarub topical ointment jars, unlabelled, in an unlocked cupboard in the Therapy area on the North 2nd floor; and
-1 Vitarub topical ointment jar, unlabelled, in an unlocked cupboard in the Bathroom/tub area on the North 2nd floor across from Room #327.
The inspector gave all of the Vitarub jars to staff #109 who agreed that medication should be in a locked cupboard.
On October 28, 2014, the DOC confirmed to Inspector #575 that the Home had not considered Vitarub a medication, however they do now and that Vitarub is no longer stored in the Therapy/tub areas of the Home.

The licensee failed to ensure that drugs are stored in an area that is secure and locked. [s. 129. (1) (a)]

Issued on this 31st day of October, 2014

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