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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 12, 2015	2015_320612_0008	S-000870-15	Critical Incident System

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

SARAH CHARETTE (612)

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): May 6th and 7th, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Residents and Families of Residents.

The inspector(s) also reviewed residents' health care records, investigation notes and some policies and procedures, walked though various resident care areas, observed the delivery of resident care and staff-to-resident interactions.

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.

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	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy that promotes zero

tolerance of abuse and neglect of residents was complied with.

Inspector #612 reviewed a Critical Incident (CI) Report which alleged that S# 102 abused residents #001, #002 and #003.

According to the CI the first incident occurred in 2014 and was reported to S#101 five months later, by S# 103 in a written statement. S# 103 witnessed S# 102 talking to resident #001 with a raised voice. S#102 yanked resident #001's arm up so hard that the resident lifted off the bed. S# 103 also witnessed S# 102 abruptly transfer resident #001 by swinging resident's feet into the bed with more force than what was necessary. Resident #001 started yelling, S# 102 then told resident #001 "that was enough and stop acting like a two year old."

According to the CI the second incident occurred in 2015 and was reported to S#101 one month later, by S#104 in a written statement. Resident #001 was exhibiting responsive behaviours. S#102 took resident #001's arm and brought it to the resident's mouth and told resident that they can bite themselves. S#104 reported that S#102 flung resident #001's legs forcefully onto bed. Resident #001 continued to exhibit responsive behaviours and stated "you hurt me". S#102 stated "ow, ow, ow you hurt me too." Resident then called S# 102 an inappropriate word which S#102 called resident #001 the same thing. S#104 reported another incident, with another resident, in the same written statement. S# 104 and S #102 were providing care to resident #002, who was exhibiting responsive behaviours and crying. S#102 was mocking resident #002, as though she was crying and stated "wao, wao, look at me you're hurting me too, I can cry too".

According to the CI the third incident occurred in 2015 and was reported to S#101 eight days later by S#105, in a written statement. S#105 witnessed S#102 roughly transfer resident #003. S#102 grabbed resident #003 by the arm when resident was sitting and "yanked" resident up. S#105 was concerned about bruising and reported the incident to registered S#106, who was unable to visualize any bruising that shift. S#105 did not report the incident to the charge nurse.

Inspector #612 reviewed the home's Prevention of Abuse and Neglect Policy, volume 8 section 4.0 Z.1. The policy stated the home is committed to zero tolerance of abuse or neglect. Physical abuse is defined, in the policy, as the use of physical force by anyone other than a resident that causes physical injury or pain, it does not include the use of force that is appropriate to the provision of care unless that force used is excessive in the circumstances. Verbal abuse is defined as any form of verbal communication of a

threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The policy stated that staff are to report any witnessed, suspected, or alleged abuse to the charge nurse immediately. The registered staff are to 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.

S#103, #104 and #105 witnessed abuse by S#102 toward resident #001, #002 and #003 and did not report it immediately as outlined in the home's abuse policy.

Inspector #612 interviewed S#104, S#107, S#108, S#109, S#110. S#111, S#112, S#113 and S#114 who all confirmed that if they witnessed abuse/neglect or if it was reported to them, they would report to their supervisor/ charge nurse/ manager immediately as per the home's policy. [s. 20. (1)]

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 home's Prevention of Abuse and Neglect Policy is complied with, specifically regarding staff reporting incidents immediately, as directed, 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. (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 failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

Inspector #612 reviewed a Critical Incident (CI) Report which alleged S# 102 abused three residents.

Inspector #612 reviewed the investigation notes, provided by the home, related to the incidents of alleged abuse by S#102. S# 105 provided a written statement to the home which alleged S# 102 transferred resident # 004 independently and did not wait for S#102 to assist.

Inspector #612 reviewed resident #004's care plan. Resident #004 was identified as requiring two staff for transfer under the transferring focus.

Inspector #612 spoke with S# 101, S# 113 and S#114 who all confirmed that resident #004 was to be transferred by two staff at all times. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Inspector #612 reviewed a Critical Incident (CI) Report which alleged S# 102 abused three residents.

Inspector #612 reviewed the investigation notes, provided by the home, related to the incidents. S# 104 alleged that while providing morning care to resident #002, with S# 102, resident #002 started exhibiting responsive behaviours including crying. S# 102 started making sounds as though they was crying and said to resident #002 "waa waa look at me your hurting me too, I can cry too."

Inspector #612 interviewed S# 104 who confirmed the events as described in the CI. S# 104 reported that the common interventions when resident was having behaviours was to approach resident calmly and don't rush resident. S# 104 confirmed that if resident is exhibiting behaviours, staff can leave resident as long as they are safe and re-approach resident later. Inspector #612 spoke with S# 110 and S#111 who confirmed these were effective interventions to manage resident #002's behaviours.

Inspector #612 reviewed resident #002's care plan which had numerous interventions listed to manage resident's responsive behaviours. Under the verbal/physical aggression focus, inspector #612 noted the following:
1. Speak to resident with a calm and reassuring manner.
2. If resident was resisting care, staff should not rush resident as resident reacts by increasing resident's verbal and physical aggression.
3. If strategies listed in the care plan were not working, then staff should leave resident and re-approach as long as resident is safe. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Inspector #612 reviewed Critical Incident (CI) Report which alleged S# 102 abused three residents.

Inspector #612 reviewed the investigation notes, provided by the home, related to the incidents. S# 104 alleged that during a shift at the end of March, 2015, resident #001 was exhibiting responsive behaviours including yelling out while staff were toileting resident. S# 102 took resident 001's arm and put it to resident's mouth and told resident to bite themselves. S# 104 and S# 102 were transferring resident to bed. S# 104 was supporting resident #001's upper body. S# 104 stated that S# 102 flung resident's legs forcefully and abruptly into bed. S# 104 wrote in the investigation notes that resident #001 was becoming more agitated and their responsive behaviours were increasing. Resident #001 was saying that staff had hurt them. S# 102 replied back to resident "you hurt me too". Resident #001 swore at S# 102, calling them an inappropriate name. S# 102 called resident the same inappropriate name.

S# 103 reported another incident to S#101, that occurred in 2014. Resident #001 was having difficulty settling and kept yelling, stating they wanted to get up. S# 102 grabbed resident with one hand under their arm by their arm pit and the other above their arm and yanked resident up so hard that resident #001 lifted off the bed. Later that same shift, S #103 and #102 were assisting resident back to bed. S# 103 had resident's shoulders and S# 102 abruptly swung resident's feet into bed with more force than was necessary. S#103 stated that resident was startled, then resident started yelling. S# 102 stated "that was enough" to resident #001 and said to "stop acting like a two year old".

Inspector #612 reviewed resident #001's care plan. Interventions listed under verbal aggression included the following:

1. Accept resident's anger, do not react to it, speak in a calm, firm and reassuring manner at all times.
2. Do not express your anger or impatience verbally or with physical movements as these responses are likely to increase confusion and agitation.
3. Staff should give resident #001 as much control as possible over routines and treatments.

Inspector #612 spoke with S#104, S#107 and S#109 who confirmed the interventions listed in the care plan as effective for managing resident #001’s responsive behaviours. [s. 6. (7)]

Issued on this 15th day of June, 2015

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

Original report signed by the inspector.