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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 1, 2016	2016_273638_0008	000468-16	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

RYAN GOODMURPHY (638)

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 9 - 11, 2016.

This inspection was completed as a result of two Critical Incidents submitted to the Director related to an incident, in which the two residents involved were not properly assessed, resulting in the risk of harm to these residents and a second incident which caused an injury to a resident.

A complaint inspection related to facility maintenance and resident safety was conducted concurrently with this inspection. For details, please see inspection #2016_273638_0009.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Support Services (DSS), Registered Nurse (RN), Personal Support Workers (PSW) and Housekeeping Aids.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health records and reviewed numerous licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
2 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	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 has failed to ensure that the written policy to promote zero tolerance of

abuse and neglect of residents had been complied with.

Neglect is defined as having failed to provide a resident with treatments, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more resident. O. Reg. 79/10, s. 6.

A Critical Incident Systems (CIS) report was submitted to the Director in October 2015. The incident had indicated residents #002 and #003 having not been properly assessed by RPN #100 after a fall had occurred.

a. A review of the home's internal investigation completed by the DOC revealed that in October 2015, resident #002 and #003 had both sustained a fall. Resident #002 and resident #003 complained of pain once the incident had occurred. PSW #101 reported the incident to RPN #100 who directed PSW #101 not to mention the incident in order to avoid reporting and charting the incident.

Further review of the internal investigation by the DOC revealed that two days after the incident, PSW #101 retold the events to RN #102 who then suggested to PSW #101 to report the incident. The incident was then only reported to the Administrator after an additional three days had passed.

A review of the “Prevention and Management” section of the home’s policy titled “Zero Tolerance of Abuse, Notification Re Incident, Police Notification & Evaluation” revealed staff were expected to report witnessed, suspected or alleged incidents of abuse or neglect immediately.

An interview with PSW #101 revealed that they had witnessed the incident in which residents #002 and #003 fell, resident #002 and resident #003 both complained of pain after the fall. Upon calling for assistance, RPN #100 responded to the incident and stood the residents up without performing the appropriate assessments or care related to falls or potential head injuries as per the home’s policy.

Further interview with PSW #101 revealed that they believed RPN #100 had provided improper care to residents #002 and #003 during the incident in October 2015, and that the suspected neglect was only reported to the Administrator five days later. PSW #101 revealed that the Administrator then informed the staff member about the immediate reporting policy and that they should have reported the incident sooner.

b. A review of the internal investigation revealed that RPN #100 had failed to provide the proper post fall care and assessments required as per the home's policy titled "Fall Prevention and Management Program" for residents #002 and #003 when both residents fell.

An interview with PSW #101 revealed that RPN #100 had not performed any post fall assessments or documentation of the incident for residents #002 and #003 as laid out within the home's fall prevention policy and by not doing so PSW #101 believed RPN #100 had provided neglectful care, which jeopardized the well being of the residents involved.

A review of the home's policy titled "Fall Prevention and Management Program" revealed that every incident in which a fall had occurred required a post fall assessment including; a completed head to toe assessment, having notified the attending physician as well as resident's Power of Attorneys (POA), initiate Head Injury Routine (HIR) for any unwitnessed fall and witnessed falls where a possible head injury occurred, completed a post Fall Investigation Report and had documented the events within the progress notes of the resident.

A review of the progress notes for resident #002 and resident #003 revealed that RPN #100 had not completed the required documentation within the progress notes as per the home's fall prevention policy indicating that the incident had occurred.

An interview with the Administrator and DOC revealed that it is the home's expectation for staff to have immediately reported any neglect of care to ensure safety of residents within the home. The DOC went on to confirm that RPN #100 had failed to provide residents #002 and #003 with the care required after their falls and the inaction of care had jeopardized the well being of the residents involved and that this was not acceptable. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident had been assessed and that a post fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident Systems (CIS) report was submitted to the Director in October 2015, where residents #002 and #003 were not properly assessed by RPN#100 after a fall occurred in which both residents were involved as witnessed by PSW #101.

An interview with PSW #101 revealed that they had witnessed the incident in which resident #002 and #003 fell, resident #002 and resident #003 both complained of pain after the fall. Upon calling for assistance, RPN #100 responded to the incident and stood the residents up without performing the appropriate assessments or care related to falls as per the home's policy.

A review of the progress notes for resident #002 and resident #003 revealed that no documentation of the fall had been completed indicating the incident had occurred.

A review of the home's internal investigation notes revealed that residents #002 and #003 had both sustained a fall and that RPN #100 had failed to complete the home's required assessments and documentation post fall for both residents.

A review of the home's policy titled “Fall Prevention and Management Program” revealed that every incident in which a fall had occurred required a post fall assessment including;
- A completed head to toe assessment
-Having notified the attending physician as well as resident's Power of Attorneys (POA) of the fall and status of the resident
-Initiate Head Injury Routine (HIR) any unwitnessed fall and witnessed falls where a possible head injury occurred

-Had completed a post Fall Investigation Report
-Documented the events within the progress notes of the resident

An interview with RN #102 revealed that for every fall a full head to toe assessment is completed. Further interview revealed Head Injury Routine (HIR) would have been implemented if the fall was unwitnessed or a suspected head injury occurred, the family and physician would be notified, the post fall investigation completed and events documented in the resident's progress notes.

An interview with the Administrator and DOC revealed that for the incident occurring in October 2015, both residents #002 and #003 had sustained falls which had not been properly assessed post fall. The DOC then confirmed that RPN #100 had not followed the proper protocols for post fall assessments and this was not acceptable. [s. 49. (2)]

Issued on this 1st day of June, 2016

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

Original report signed by the inspector.