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

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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 7, 2017	2017_638609_0015	017879-16, 028913-16, 030591-16, 034099-16, 000412-17, 010494-17	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. BOX400 POWASSAN ON P0H 1Z0

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

CHAD CAMPS (609), LOVIRIZA CALUZA (687), NATASHA MILLETTE (686)

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): June 26-30, 2017.

This inspection was conducted as a result of: One Critical Incident (CI) report the home submitted to the Director related to an unexpected death of a resident; Three CI reports the home submitted the Director related to resident falls; One CI report the home submitted related to resident to resident abuse and; One CI report the home submitted to the Director related to staff to resident abuse.

A complaint inspection #2017_638609_0014 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Physicians, Director of Nursing (DON), Director of Administrative Services, Nursing Administrative Assistant (AA), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family of residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 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. 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 the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted by the home to the Director outlining how resident #004 fell related to improper care provided by RPN #109.

Inspector #687 reviewed the home's internal investigation of the incident and found that RPN #109 left resident #004 unattended in an identified area, while using their mobility aid. Subsequently, PSW #106 attended resident #004 and found the resident had fallen on the floor while using their mobility aid.

During an interview with RPN #105 they verified they were present and working on the particular day and responded to resident #004's fall. RPN #105 stated that the resident was found fallen in the identified area, while using their mobility aid. At the time of the fall RPN #105 was told by RPN #109 that they had left resident #004 unattended in the identified area, while the resident was using their mobility aid.

A review of resident #004's plan of care at the time of the fall indicated that the resident was not to be left unattended the identified area.

A review of the home's policy entitled "Care Plan" last reviewed June 2017 indicated that staff were to follow the care plan to provide direction to staff to meet the needs of each resident in a consistent manner.

During an interview with the DON they verified that staff were to provide care to residents as specified in their plans of care. The DON further verified that RPN #109 did not provide care as specified to resident #004 and as a result received disciplinary action. [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 #004 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee was required to institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that it was complied with.

A Critical Incident (CI) report was submitted to the Director, which outlined how on a particular day, resident #001 fell in the home and was transferred to hospital with an injury.

Inspector #686 reviewed resident #001's health care records and found in the post fall investigation progress note, that resident #001 got caught on an identified piece of equipment and fell. The resident was transferred to the hospital and admitted with an injury.

During an interview with PSW #100 they verified they were present, working and

witnessed resident #001 fall when they got caught on an identified piece of equipment.

A review of the CI report by the Inspector, indicated that long term actions to prevent recurrence was that resident #001 did not require the identified piece of equipment, that it would be evaluated, and if able would be removed.

On a particular day, the Inspector observed resident #001 and noted the identified piece of equipment.

During an interview with resident #001 they indicated they remained fearful of falling.

A review of the home's policy "Fall Prevention and Management Program" last revised March 2017 indicated that environmental risk factors for residents were to be identified, reduced and/or eliminated.

During an interview with RN #104 resident #001's post fall investigation was reviewed. RN #104 verified that the identified piece of equipment was a potential environmental risk factor for falls.

During an interview with the DON they verified that environmental risk factors for residents were to be identified, reduced, and/or eliminated related to falls.

During an interview with the DON they indicated that resident #001 had an updated analysis completed and the identified piece of equipment was deemed an environmental risk factor and was removed, over six months after the identified piece of equipment was identified as an environmental risk factor for falls. [s. 8. (1) (b)]

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 o ensure that where the licensee is required to institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that it is complied with, to be implemented voluntarily.

WN #3: 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 had failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director which outlined allegations of emotional and physical abuse by PSW #107 toward resident #005 on an identified day, as well as other occasions previously. The allegations described PSW #107's conduct as rough during care as well as making the resident feel like a burden and an inconvenience when requesting care.

O. Reg 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

The regulations also defines physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.

A review of PSW #107's human resources file found two previous incidents of inappropriate behaviour impacting residents and staff whereby the PSW received disciplinary action.

Inspector #609 reviewed resident #005's most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) which found that the resident had good memory recall.

During an interview with resident #005 they verified that on the particular day, PSW #107 rushed through their care and transferred them using an assistive device which caused

them pain. The resident described how this was a common occurrence and that PSW#107 had caused them pain multiple times previously by rushing through their care.

Resident #005 further told the Inspector how on the particular day, they asked PSW #107 to assist them with care and was verbally abused by PSW #107, who refused to assist them, which made them feel like a "burden" and "not right". The resident indicated that these emotionally abusive incidents had occurred multiple times previously by PSW #107.

A review of the home's policy titled "Zero Tolerance of Abuse, Notification re Incident, Police Notification and Evaluation" last revised July 2016 indicated that the home was committed to zero tolerance of abuse or neglect.

During an interview with the DON a review of the home's internal investigation into the allegations was conducted. The investigation found that PSW 107's conduct was perceived by resident #005 as rough when using an assistive device and that the resident's perception of the PSW's demeanor made them feel like a burden.

The investigation resulted in PSW #107 receiving coaching related to verbal and non-verbal interactions with residents.

PSW #107 further apologized to resident #005 and was noted to be remorseful. [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 zero tolerance of abuse and neglect of residents policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital and where the licensee determined that the injury had resulted in a significant change in the resident's health condition, informed the Director of the incident no later than three business days after the occurrence of the incident.

A CI report was submitted to the Director which outlined how on a particular day resident #001 fell in the home, and was transferred to hospital with an injury.

Inspector #686 reviewed resident's #001 heath care records and found in a progress note that indicated that resident #001 had a fall and was sent to hospital with an injury. A subsequent progress note indicated that the home was verified by the hospital that resident #001 had an injury.

A review of the home's policy titled "Critical Incident" effective August 2011 indicated that the Director should have been informed the incident no later than one business day.

During an interview with the DON and AA a review of the CI report was conducted. The DON verified that the home became aware that resident #001 had a significant change in their health condition and did not inform the Director until two business days later than required, when the AA submitted the CI. [s. 107. (3.1)]

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Issued on this 10th day of August, 2017

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

Original report signed by the inspector.