Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: October 5, 2023	
Inspection Number: 2023-1542-0003	
Inspection Type: District Initiated Critical Incident	
Licensee: The Board of Management for the District of Parry Sound East	
Long Term Care Home and City: Eastholme Home for the Aged, Powassan	
Lead Inspector Amanda Belanger (736)	**Inspector Digital Signature** Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2023.10.11 13:49:12 -04'00'
Additional Inspector(s) Charlotte Scott (000695) Jennifer Nicholls (691)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14-18, 2023.

The following intake(s) were inspected:

- one intake related to an allegation of neglect of a resident by staff;
- three intakes related to improper/incompetent care of residents by staff; and,
- one intake for District Initiated inspection of the Management of Responsive Behaviours program.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Positioning when Feeding

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O.Reg 246/22, s. 79 (1) 9

The licensee has failed to ensure proper feeding techniques were used when assisting the resident.

Rationale and Summary
The resident was discovered by the Registered Practical Nurse (RPN) being assisted with their meal by a Personal Support Worker (PSW) in an unsafe position for feeding.

The Director of Care (DOC) indicated that the PSW was assisting the resident did not follow proper techniques used to assist residents with feeding.

Sources: Critical Incident Report (CIR); investigation notes; record review of the resident's care plan, and electronic medical record; home's policy titled" "Dining Service-Feeding", last reviewed August 2023; and, interview with the DOC, RPN, and other staff.

[691]

COMPLIANCE ORDER CO #001 Safe Lifts and Transfers

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Develop and implement an auditing process for the two residents, to ensure that staff are utilizing safe lifts and transfers, including any corrections related to deficiencies for a period of four weeks. Analyze the result of the audits, and provide retraining to correct any noted deficiencies. These documents are to be made available to the Inspector upon request;

B) Conduct safety talks on the home areas of the two residents for all PSWs, agency PSWs, and student

PSWs, related to safe lifts and transfers, utilizing appropriate physical assistance, and following the residents plans of care. The home shall keep records of each safety talk, including who provided the information, the date of the safety talk, what information was covered, and who attended the safety talks.

C) Conduct a documented review of the plans of care for the two residents to ensure that the plan of care provides clear direction to the staff and is consistent with relevant assessments, including any corrections related to deficiencies. These documents are to be made available to the Inspector upon request.

Grounds
The licensee has failed to ensure that staff members used safe transferring and positioning devices or techniques when assisting three different residents.

Rationale and Summary
Two staff members independently transferred three different residents independently without a second staff member present. The residents' plan of care at the time of the incident indicated the residents each required two staff for transfers.

The DOC indicated the two staff members did not use safe transferring techniques when assisting the residents.

There was no injury to the residents as a result of this incident, however, there was moderate risk of injury to the three residents, as all the plans of care specified that the residents required two staff for their transfers.

Sources: LTCH investigation notes; residents' plan of care; and interviews with the DOC , PSW, RPN, and other staff.

This order must be complied with by December 1, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.