Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 29, 30, Dec 10, 11, 2012	2012_140158_0030	Critical Incident

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), several Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and visitors.

During the course of the inspection, the inspector(s) reviewed a resident's health care record, various home's policies, including Responsive Behaviours and observed staff interaction during the delivery of resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Responsive Behaviours

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the 24-hr admission care plan set out clear directions to staff and others who provide direct care to the resident. The home submitted a report to the Director identifying that resident # 01 had eloped from the home and was missing for less than three hours. Resident # 01 was admitted to the home and approximately three hours after being admitted, a member of the community called the home to inform them that, resident # 01 was seen walking one block away from the home. The resident was returned to the home without incident. The home's " Identification of Responsive Behaviours on Admission " assessment form was reviewed by the Inspector on November 30, 2012 and the assessment did not identify the resident's exit- seeking behaviour. Resident # 01 wandering was documented in the 24-hr admission care plan, however, the risk of exit-seeking is not identified. Interventions, such as "Watchmate and Wandering Registry" was identified on the care plan as well, but clear direction to manage resident # 01 exit seeking behaviour is not set out in the care plan. [O Reg 79/10, s. 24 (3) (b)]

Issued on this 11th day of December, 2012