Ontario

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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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 12, Dec 6, 12, 2011	2011_056158_0011	Complaint

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 Complaint 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), several residents and family members.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, the home's policy related to Responsive Behaviours, and observed resident care.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. A RPN stated to the inspector on Sept. 12/11 that there is a resident who is fearful of another resident on the unit who has 'angry/aggressive' outbursts. The RPN identified that the resident who is fearful requested that the bedroom door be closed at night to deter this 'angry/aggressive' resident from entering the bedroom. The RPN also identified that when this 'angry/aggressive' resident becomes agitated and is wandering the unit, the other residents on the unit are asked to remain in their rooms while the staff redirect and manage this 'angry/aggressive' resident's behaviour.
The inspector spoke with the resident who is fearful on Sept. 12/11 and the resident confirmed their fears regarding this 'angry/aggressive' resident.
The anxiety of the resident who is fearful was not reflected in the plan of care. Clear direction to staff and others who provide direct care regarding the management of the anxiety of the resident who is fearful was not set out in the resident's written plan of care. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]

2. An incident involving the 'angry/aggressive' resident and a second resident who is fearful occurred several months ago. The progress notes of the resident who is fearful identified the fears. Strategies to manage the resident's fears were not documented in the resident's plan of care even though a RPN was able to verbally identify the strategies used to the inspector on Sept.12/11.
The resident who is fearful also confirmed that the fears continue but the staff know how to keep the residents safe when the 'angry/aggressive' resident exhibits outbursts. The plan of care did not set out clear direction to staff and others who provide direct care to the second resident who is fearful.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]

3.The computerized plan of care identified that a resident is "continent - complete control" of urine. The plan of care also stated that the resident voiced that stress incontinence occurs daily which is contradictory.
The printed plan of care which is accessible to the front line staff identified that the resident is "frequently incontinent (of urine) but has some control present".
The PSW's flow sheets were reviewed by the inspector and identified that the resident is incontinent daily.
The plan of care did not set out clear direction to staff and others who provide direct care to the resident.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]

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Issued on this 15th day of December, 2011

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