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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Dec 11, 2015	2015_395613_0017	026488-15	Resident Quality Inspection

Licensee/Titulaire de permis

ESPANOLA GENERAL HOSPITAL
825 MCKINNON DRIVE ESPANOLA ON P5E 1R4

Long-Term Care Home/Foyer de soins de longue durée

ESPANOLA GENERAL HOSPITAL (2932)
825 MCKINNON DRIVE ESPANOLA ON P5E 1R4

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

LISA MOORE (613), GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 26 - 30 and November 2-3, 2015

This inspection addresses both the Espanola General Hospital Long Term Care Unit #2932 and the ELDCAP Unit #2755.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses, Personal Support Workers, Recreation & Restorative Care Coordinator, Ward Clerk, Residents and Family members.

During the course of the inspection, the Inspectors conducted a walk through of the resident home areas and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out the planned care for resident #002 regarding the use of bed rails.

Inspector #593, observed, multiple times during the inspection, resident #002's bed with a half rail and assist rail in the up position.

A review of resident #002's current care plan found nothing documented relating to the use of bed rails for this resident.

During an interview with Inspector #593, October 30, 2015, S#106 reported that there were no safety requirements for the use of the bed rails with resident #002 and the resident was able to put the bed rails up or down as they choose. S#106 added that resident #002 used the bed rails for mobility.

During an interview with Inspector #593, November 2, 2015, resident #002 advised that they used the half rail so that they did not fall out of bed and the assist rail was used to hold onto when getting out of bed.

During an interview with Inspector #593, November 3, 2015, S#113 reported that resident #002 used the bed rails for bed mobility however they were unsure if resident #002 used a half rail or a full rail and that this information would be in the resident's care plan. S#113 added that if this information was not in the care plan, then it would not be located anywhere else in the resident's health care record.

During an interview with Inspector #593, November 3, 2015, S#114 reported that they were not sure but believed that resident #002 used the bed rails to get in and out of bed. S#114 added that resident #002 had been using the bed rails since they received a new bed several months earlier.

During an interview with Inspector #593, November 3, 2015, the Director of Care reported that resident #002 used the bed rails to hold onto when getting in and out of bed and the resident could put the bed rails up and down as they choose. The Director of Care confirmed that this information was not included in the resident's plan of care.

A review of the home's Policy: Bed Entrapment Prevention program, last reviewed March 2015, found documented that bed rail use for resident's mobility and/or transferring, for

example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, would be reflected in the care plan. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident regarding the use of bed rails.

Inspector #613 observed resident #001's bed to have a 3/4 length bed rail in the up position at all times on one side of their bed and a 1/4 rail on the other side of the bed.

The Inspector reviewed the most recent care plan that was accessible to staff and noted there was no documentation for bed mobility or for the use of the 3/4 or 1/4 bed rails. There were no interventions in the care plan that identified the use of resident #001's bed rails. The Inspector reviewed the resident's paper and computer record on Point Click Care. There were no physician's order or reason in the progress notes for the use of resident #001's bed rails. A form titled, 'Espanola Nursing Home Release Form' was signed by resident and witnessed by S#115 on February 28, 2012 identifying that resident wished to have bed rails down. There was no current form since that date signed by the resident to consent to the use of the bed rails. There were no reassessment or evaluation in resident's chart for the use of the bed rails.

Inspector #613 met with S#110 who reported resident #001 used the bed rails as it was their preference for security and transferring in and out of bed.

S#110 reviewed resident #001's most recent care plan that was accessible to all staff and confirmed to Inspector #613 that there was no information or interventions in the care plan related to the use of resident #001's bed rails.

It was unclear in resident #001's plan of care why resident had the bed rails and there was no direction for staff when to apply and or remove.

The Inspector reviewed the home's policy, titled,'Bed Entrapment Prevention Program', reviewed March 2015, that identified the bed rail use for resident's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, would be reflected in the care plan. [s. 6. (1) (c)]

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 there is a written plan of care for residents #001 and #002 that sets out the planned care for the residents and provides clear directions to staff and others who provide direct care to residents #001 and #002, regarding the use of bed rails, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system for residents #001, #003, #004, #005, #006 and #007 could be easily seen and accessed by residents, staff and visitors at all times.

Inspector #613 observed residents #001, #003, #004, #005, #006 and #007 daily from October 26 to 30, 2015 and noted the call bell systems in these residents' rooms were

not easily seen or accessible to these residents when they were in their rooms.

During Stage 1, Inspector #613 observed the following;

Resident #001 sitting in a chair in their room, the call bell was clipped to its cord and wrapped around the bed rail and was out of resident's reach.

Resident #003 lying on their right side in bed, the call bell was dangling from the wall with one loop of the cord wrapped around the left bed rail with call bell lying on the floor, hidden by the privacy curtains. The call bell was not easily seen for visitors or resident and was out of the resident's reach.

Resident #004 sitting in a chair in their room, the call bell was clipped to its own cord, hanging from the wall and was out of the resident's reach.

Resident #005 sitting in a chair in their room, the call bell was lying across the bed side table and was out of the resident's reach.

Resident #006 lying in bed sleeping and call bell was lying on the floor, underneath the bed. The call bell was not easily seen for visitors or residents and was out of the resident's reach.

Resident #007 was lying in bed and call bell was clipped to its own cord, hanging from the wall out of the resident's reach.

The Inspector met with S#107 and S#108 who both reported that when staff put residents in their rooms they were responsible to ensure that the call bells are placed within the residents' reach.

Inspector reviewed each resident's care plan. Only resident #003's care plan identified as an intervention to have the call bell within resident's reach when in bed. The other resident's (#001, #004, #005, #006 and #007) care plans did not have any documentation in regards to the placement of the call bells to ensure they were easily seen and accessible to residents, staff and visitors at all times.

On October 30, 2015, Inspector #613 met with the Director of Care who confirmed that it was the home's expectation that all the residents' call bells were to be within reach for the residents at all times. [s. 17. (1) (a)]

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 residents #001,#003, #004, #005, #006 and #007 have their resident-staff communication response system in an easily seen and accessible area for use by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with.

A review of resident #003's current care plan found that the resident was at risk for falls characterized by a history of falls with injury. The interventions documented to manage this included two bed rails up at all times when in bed for safety. A review of resident #003's quarterly falls risk assessments identified that resident #003 was a high risk for falls.

During an interview with Inspector #593, November 3, 2015, the Director of Care reported that the bed rails used for resident #003 were for safety and bed mobility and therefore, they would consider them both a PASD and a restraint. The Director of Care confirmed that they had not obtained a physician's order for the use of the two full bed rails when the resident was in bed.

A review of the home's Policy: Restraint Policy, last reviewed July 2010, found that a restraint is only applied on written order of a Physician who had attended the resident and approved the type of restraint.

Inspector #593, observed, multiple times during the inspection, resident #002's bed with a half rail and assist rail in the up position. A review of resident #002's current care plan found nothing documented relating to the use of bed rails for this resident.

During an interview with Inspector #593, November 3, 2015, the Director of Care reported that resident #002 used the bed rails to hold onto when getting in and out of bed and the resident could put the bed rails up and down as they choose. They confirmed that this was not included in the resident's plan of care.

A review of the home's Policy: Bed Entrapment Prevention program, last reviewed March 2015, found documented that bed rail use for resident's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, would be reflected in the care plan. [s. 29. (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 by ensuring the policy to minimize the restraining of residents #002 and #003 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that restraining of a resident by a physical device was included in a resident's plan of care only if a physician or registered nurse in the extended class has ordered or approved the restraining.

A review of resident #003's current care plan found that the resident was at risk for falls characterized by a history of falls with injury. The interventions documented to manage this included two bed rails up at all times when in bed for safety. A review of resident #003's quarterly falls risk assessments identified that resident #003 was a high risk for falls.

During an interview with Inspector #593, October 30, 2015, S#105 reported that resident #003 had two full bed rails in place when in bed. They added that the purpose of the bed rails was to prevent the resident from falling out of bed and that resident #003 was high risk for falls. S#105 further indicated that the bed rails had been used for this resident for "years".

During an interview with Inspector #593, November 2, 2015, S#111 reported that resident #003 used two full bed rails when in bed which they used to reposition them self. They added that the bed rails were also in place to prevent the resident from falling out of bed.

During an interview with Inspector #593, November 3, 2015, S#112 confirmed that resident #003 used two full bed rails when in bed and the resident was a falls risk. They added that resident #003 used the bed rails to hold onto when being changed as well as used them as a support to lean on when in bed.

During an interview with Inspector #593, November 3, 2015, the Director of Care reported that the bed rails used for resident #003 were for safety and bed mobility and therefore, they would consider them both a PASD and a restraint. The Director of Care confirmed that they had not obtained a physician's order for the use of the two full side rails when the resident was in bed.

A review of the home's Policy: Restraint Policy, last reviewed July 2010, found that a restraint is applied on written order of a Physician who had attended the resident and approved the type of restraint. [s. 31. (2) 4.]

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 by ensuring that the restraining of resident #003 by a physical device is included in the resident's plan of care only if a physician or registered nurse in the extended class has ordered or approved the restraining, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the bed rail (PASD) to assist resident #001 with a routine activity living was included in resident #001's plan of care.

Inspector observed resident #001 to have a 3/4 length bed rail in the up position at all times on one side of their bed and a 1/4 rail on the other side. Inspector reviewed the most current care plan that was accessible to staff on Point Click Care. There was no mention of bed rail use or bed mobility in the care plan.

Inspector met with the Director of Care who confirmed that bed rails on resident #001's bed were not a restraint but rather considered a PASD to assist resident with bed mobility. The Director of Care identified it was the resident's choice and preference to have bed rails on their bed. The Inspector informed the Director of Care that there was no information on resident #001's plan of care to support staff with the use and interventions of the bed rails. The Director of Care was unaware this information was not included in resident #001's care plan. [s. 33. (3)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving the Residents' Council advice related to their concerns or recommendations.

On October 29, 2015, Inspector #613 met with the President of the Residents' Council who informed the Inspector that they had never received a written response letter from the licensee related to concerns or recommendations.

Inspector #613 reviewed the home's policy titled, 'Resident Council' (last reviewed September 2014) which identified that suggestions and complaints from Residents' Council are documented, investigated by the Administrator or designate and responded to in writing within 10 days to the Council.

The Inspector reviewed the last three Residents' Council minutes (October 5, 2015, September 14, 2015 and June 1, 2015). It was noted that there was no written response from the licensee addressing resident concerns.

Inspector met with S#102 who was appointed Assistant to the Residents' Council. S#102 provided the Inspector with written responses from the February and March 2015 Residents' Council meeting. However, the written responses were not dated and did not identify who the responses were received from. The Residents' Council minutes did not identify that these responses were reviewed by Residents' Council.

Inspector #613 met with the Director of Care who indicated that they generally respond verbally to the residents as soon as they are made aware of the concern. The Director of Care was unable to provide documentation to the Inspector that supported a written response was provided to Residents' Council within 10 days. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that concerns or recommendations from the Family Council are responded to in writing, within 10 days of receiving the advice.

A review of the Family Council Minutes May and September 2015, found multiple concerns and recommendations from the Family Council to the licensee of the home. There were no written response from the licensee to the Family Council regarding this advice.

During an interview with Inspector #593, November 2, 2015, Family Council member reported that they did not receive any written response from the licensee regarding the concerns and recommendations raised during the Family Council meetings.

During an interview with Inspector #593, November 2, 2015, S#102 reported that the licensee did respond to the concerns and recommendations raised during Family Council meetings however this was not done so in writing.

During an interview with Inspector #593, November 3, 2015, the Director of Care confirmed that they had received recommendations or concerns by email from the Family Council Assistant, which they addressed, however a written response was not provided to the Family Council regarding how their concerns or recommendations were addressed. [s. 60. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the annual resident satisfaction survey and in acting on its results.

During an interview with Inspector #593, November 2, 2015, Family Council member reported that they were unsure if the annual resident satisfaction survey was developed with advice from the Family Council.

During an interview with Inspector #593, November 2, 2015, S#102 reported that the Family Council was not involved in the development or implementation of the annual resident satisfaction survey.

During an interview with Inspector #593, November 3, 2015, the Director of Care confirmed that a resident satisfaction survey was completed in May or June of each year however there was definitely no Family Council involvement in the development or implementation of the survey. [s. 85. (3)]

2. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on its results.

On October 29, 2015, Inspector #613 met with the President of the Residents' Council who informed the Inspector that they did not recall seeing a satisfaction survey, the results or making recommendations regarding it.

The Inspector met with S#102 who was appointed Assistant to the Residents' Council. S#102 informed the Inspector that a Satisfaction survey was done in 2015 but was unable to provide documentation to support that the licensee sought the advice of the Resident Council in developing and carrying out the satisfaction survey or reviewing the results with them.

Inspector #613 met with the Director of Care who provided the Inspector with completed Satisfaction Surveys. However, the surveys provided were not dated and some survey results were identified as being from 2011 and 2012. There was no documentation to identify that the results were from 2015. The Director of Care confirmed that results were not dated and she could not provide supportive documentation that identified that Satisfaction Surveys were provided to the Residents' Council prior to receiving recommendations or after to review the results. The Director of Care confirmed that they did not have any documentation to support that this had been done by the home. [s. 85. (3)]

3. The licensee failed to ensure that the results of the annual resident satisfaction survey were made available to the Family Council to seek their advice.

During an interview with Inspector #593, November 2, 2015, Family Council member reported that they were unsure if the results of the annual resident satisfaction survey were made available to the Family Council to seek their advice.

During an interview with Inspector #593, November 2, 2015, S#102 reported that the results of the resident satisfaction survey were not shared with the Family Council.

During an interview with Inspector #593, November 3, 2015, the Director of Care confirmed that a resident satisfaction survey was completed in May or June of each year however the results were not discussed with the Family Council. [s. 85. (4) (a)]

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Issued on this 11th day of December, 2015

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

Original report signed by the inspector.