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
Sep 6, 2017	2017_616542_0012	010005-17	Critical Incident System

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

JENNIFER LAURICELLA (542)

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 Critical Incident Inspection is related to:
One intake related to a critical incident that was submitted by the home regarding resident responsive behaviours,
Two intakes related to critical incidents submitted by the home regarding alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer, the Chief Executive Officer, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Worker, Behavioural Support Staff, Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to residents interactions, reviewed relevant health care records, and reviewed various policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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 has failed to ensure that there was a written policy that promoted zero

tolerance of abuse and neglect of residents and that it was complied with.

O. Reg. 79/10, s. 5, describes Neglect as, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) A Critical Incident (CI) report was submitted to the Director on a specific day for alleged staff to resident neglect. The CI report indicated that the alleged incident occurred four days prior to the submission to the Director. It was reported that seven residents were not provided with care as specified in their plan of care. PSW #103 and PSW #104 worked the day when the alleged neglect occurred. PSW #103 sent an email to the Director of Care (DOC) at the end of their shift stating that, one resident was not transferred back to bed after breakfast, two residents were not assisted with toileting after breakfast and one was found incontinent after lunch, four residents were not transferred to bed after lunch and one resident refused to come for breakfast and was not offered a meal tray.

On June 27, 2017, Inspector #542 interviewed the Administrator who indicated that the home had changed the PSW start and end times around the time of the incident. The management team was never made aware that they were struggling to complete all care for the residents during the day shift. PSW #103 waited until the end of their shift to email the DOC. The management team was informed that some of the staff were upset about the changing of their start and end times.

Inspector #542 was provided with the home's investigation file which included the original email that was sent to the DOC by PSW #103 on the date of occurrence. The email described that some residents were not provided with proper hygiene care, with breakfast and some were not toileted as per their plan of care which resulted in incontinence.

In a subsequent interview with the Administrator on June 28, 2017, they stated that PSW #103 and PSW #104 were neglectful towards the seven residents and received discipline.

B) Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director on a specific day for an alleged abuse/neglect that occurred ten days prior to the submission of the CI report. The CI report indicated that two residents were left for an

extended period of time in the dining room without receiving any care as per their care plans.

On June 27, 2017, the Inspector reviewed the home's investigation file. It was documented that the alleged neglect occurred on a specific day when BSO staff #105 witnessed two residents' left in the dining room for an extended period of time. The next day, BSO staff #105 reported the alleged neglect during the morning meeting. The home reviewed the video footage 15 days after the alleged incident of neglect occurred and found that resident #007 was left unattended in the dining room for two hours and resident #008 was left in the dining room unattended for seven hours. PSW #103 had documented that resident #008 had been checked every hour, however this did not occur according to the video footage. The home disciplined PSW #103 as they failed to provide care to both resident's during part of their shift and for falsification of documentation.

Inspector #542 reviewed the care plans for resident #007 and #008 and noted that both residents were dependent on staff with regards to their Activities of Daily Living (ADLS).

Inspector #542 reviewed the home's policy titled, "Abuse/Whistleblower" last reviewed in September 2016. The policy indicated that there is a zero tolerance for all forms of abuse. "The policy defined "neglect" as the failure to provide the care and assistance required for the health, safety and well-being of a resident. [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 policy to promote zero tolerance of abuse and neglect of resident is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director.

A) A Critical Incident (CI) report was submitted to the Director on a specific day for alleged staff to resident neglect. The CI report indicated that the alleged neglect of seven residents occurred four days prior to the submission of the CI report. See WN #1 for further details.

On June 27, 2017, Inspector #542 interviewed the Administrator who indicated that PSW #103 had emailed the home's previous Director of Care (DOC) outlining that they were unable to provide care to seven resident's as outlined in their plan of care on a specific day.

In a subsequent interview with the Administrator on June 28, 2017, they acknowledged the home failed to report the alleged incident of neglect immediately to the Director as it was not reported until four days later.

B) A Critical Incident (CI) report was submitted to the Director on a specific day for an alleged incident of neglect involving two residents, that occurred on 11 days prior to the submission of the CI report. It was documented on the CI report that resident #007 and

#008 were left for an extended period of time in the dining room without receiving care.

On June 27, 2017, Inspector #542 reviewed the home's investigation file. It was documented that the alleged neglect occurred a specific day when BSO staff #105 witnessed two residents' left in the dining room for an extended period of time. See WN #1 for further details.

On June 27, 2017, Inspector #542 interviewed the Administrator who acknowledged that the alleged neglect should have been reported immediately to the Director. They also stated that the previous Director of Care conducted the investigation first and then reported it to the Director 11 days after the date of occurrence, however they did not know why.

Inspector #542 reviewed the home's policy titled, "Abuse/Whistleblower" last reviewed in September 2016. It indicated that, if an employee had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff shall immediately report the suspicion to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion to the Director, to be implemented voluntarily.

Issued on this 7th day of September, 2017

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

Original report signed by the inspector.