Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2020	2019_668543_0028	022653-19	Complaint

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 (operating as Espanola Nursing Home-LTC)
825 Mckinnon Drive ESPANOLA ON P5E 1R4

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

TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 18-20, 2019.

A Critical Incident System inspection #2019_668543_0029 was conducted concurrently with this inspection.

One complaint intake submitted to the Director outlining, care related concerns regarding a fall was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Continuous Quality Improvement Manager, Registered Practical Nurse (RPN), Personal Support Worker (PSW) and family.

The Inspector conducted daily observations of the provision of care to the residents, reviewed resident health care records, relevant policies and procedures and home's investigation files.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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	Légende 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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A critical incident report was submitted to the Director, related to resident #001 falling resulting in an injury. Subsequently, a complaint was submitted to the Director, related to resident #001 falling resulting in an injury.

Inspector #543 reviewed resident #001’s electronic health care record. A progress note identified that resident #001 had been assessed in the emergency department, the assessment confirmed an injury.

Inspector #543 reviewed resident #001’s care plan, that was implemented after the resident fell. Related to mobility, the care plan indicated that the resident was dependent of two specific mobility devices.

Inspector #543 observed the resident on December 18, 19 and 20, 2019, during all observations, the resident was observed using one of the mobility devices mentioned in their care plan.

Inspector #543 interviewed PSW #104 who indicated that resident #001 utilized one of the mobility devices.

Inspector #543 interviewed RPN #105, who indicated that resident #001 required a specific mobility device. The RPN verified that the resident did not use the other mobility device mentioned in the resident's care plan.

The Inspector interviewed the acting ADOC who verified that the resident’s care plan did not provide clear direction and was confusing related to the resident’s mobility interventions. They verified that the resident was no longer independent, and required a specific mobility device. The acting ADOC confirmed that the resident did not use the other mobility device mentioned in their care plan.

Inspector #543 interviewed the DOC, who verified that the resident’s care plan did not provide clear direction. They confirmed that resident #001 required a specific mobility device. They stated that the other mobility device mentioned in the care plan should have been removed, as the resident did not utilize that specific device. [s. 6. (1) (c)]

Issued on this 8th day of January, 2020

[redacted]

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

Original report signed by the inspector.