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
Jun 4, 2020	2020_615759_0010	002498-20, 006758-20	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 (operating as Espanola Nursing Home-LTC)
825 Mckinnon Drive ESPANOLA ON P5E 1R4

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

KEARA CRONIN (759)

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): March 10-13, May 28-29, and June 1-2, 2020. Additional off-site inspection activities were completed on May 25, 2020.

The following intakes were inspected during this Critical Incident (CI) Inspection:
- Two intakes related to a fall of a resident resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Physiotherapist, and the Ward Clerk.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #001's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident Systems (CIS) report was submitted to the Director as a result of an incident that occurred in which resident #001 sustained an injury from a fall that resulted in a significant change to their status.

Inspector #759 reviewed resident #001's electronic health care records and identified a progress note written by RPN #103 that indicated that resident #001 sustained a fall in a specified location.

During separate interviews with Inspector #759, Personal Support Worker (PSW) #106, RPN #105, and RPN #108, all indicated that resident #001 had a specified transfer and mobility status. However, resident #001's current care plan indicated that resident #001 had a different transfer and mobility status. Inspector #759 identified that these interventions were last revised on a specified date, by the Assistant Director of Care (ADOC).

Inspector reviewed a "Physiotherapy Initial Assessment" that was completed on a specified date by Physiotherapist (PT) #111. It indicated that resident #001 had the same transfer status as was identified by PSW #106 and RPNs #105 and #108.

Inspector #759 interviewed the ADOC and reviewed the current care plan with them. The ADOC indicated that the care plan identified the specified level of assistance that was required when the resident initially sustained the injury. The ADOC indicated that the care plan could be changed. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention program was evaluated and updated at least annually with evidence-based practice and, if there were none, in accordance with prevailing practices.

A CIS report was submitted to the Director as a result of a fall in which resident #001 sustained an injury.

During an interview with Inspector #759, the Acting DOC indicated that program reviews were completed yearly.

On March 13, 2020, Inspector #759 reviewed the homes falls prevention policy. Inspector #759 noted that the program was last reviewed October 22, 2018.

The Acting DOC shared to Inspector #759 that they did not think the falls prevention program had been reviewed since October 22, 2018. [s. 30. (1) 3.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The Licensee has failed to immediately report an outbreak of a disease of public health significance or communicable disease to the Director.

During the inspection, Inspector #759 noted a sign on the south wing door that read “Stop. Visitors please read. Outbreak Declared”.

Inspector #759 spoke with the LTC Ward Clerk who indicated that the outbreak was declared the day prior.

Inspector #759 reviewed the Ministry of Long Term Care, Long-Term Care Homes Portal, and was unable to identify a CIS report submitted to notify the Director of the outbreak.

Inspector #759 spoke with the ADOC who confirmed that the outbreak had not been reported to the Director. [s. 107. (1) 5.]

Issued on this 8th day of June, 2020

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

Original report signed by the inspector.