Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 29, 30, Oct 3, 17, 2011	2011_099188_0018	Mandatory Reporting

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 (2755)
825 McKINNON DRIVE, ESPANOLA, ON, P5E-1R4

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Resident Care Coordinator (RCC), Registered Nursing Staff, Personal Support Workers (PSW), dietary staff, housekeeping staff and residents.

During the course of the inspection, the inspector(s) conducted the inspection in both the Elcap unit (facility #2755) and the Long Term Care unit (Facility #2932), conducted a walk through of resident care areas, reviewed the home's written policy related to prevention of abuse and neglect, reviewed investigation documentation related to the allegations of abuse, observed dining room service and resident and staff interactions.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. The home's written policy fails to contain an explanation of the duty under section 24 of the Act to make mandatory reports. Inspector spoke with the DOC who confirmed that the current policy does not include an explanation of the duty under section 24 of the Act to make mandatory reports. The licensee failed to ensure the written policy contains an explanation of the duty under section 24 of the Act to make mandatory reports. [LTCHA 2007, S.O. 2007, c.8., s.20(2)]
2. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. The policy does not provide for a program, that complies with the regulations, for preventing abuse and neglect. The licensee failed to ensure their policy provides for a program, that complies with the regulations, for preventing abuse and neglect. [LTCHA 2007, S.O. 2007, c.8., s.20(2)]

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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident. The Director was notified twelve days after the incident occurred. The licensee failed to ensure the Director was immediately informed of abuse of a resident by anyone. [[LTCHA 2007, S.O. 2007, c.8., s.24(1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Inspector spoke with four staff members including a member of the registered nursing staff, personal support workers and a dietary aid who identified they have not had training in the area of whistle-blowing protections afforded under section 26. Inspector spoke with the DOC who confirmed that training has not been provided in the area of whistle-blowing protections afforded under section 26. The licensee failed to ensure staff receive training in the area of whistle-blowing protections afforded under section 26. [LTCHA 2007, S.O. 2007, c.8., s.76(2)(5)]
2. Inspector spoke with four staff members including a member of the registered nursing staff, personal support workers and a dietary aid who identified they have not had training in the area of mandatory reporting under section 24 of the Act. Inspector spoke with the DOC who confirmed that there has not been any training for staff in the area of mandatory reporting under section 24 of the Act. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act prior to performing their responsibilities. [LTCHA 2007, S.O. 2007, c.8., s.76(2)(4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. The home's policy does identify that staff will be retrained, however fails to include training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. The licensee failed to ensure the written policy to promote zero tolerance of abuse and neglect of resident identifies the training and retraining requirements for all staff. [O.Reg. 79/10 s.96(e)]
2. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. Inspector noted it does identify the following under the procedure section "#3. The staff receiving the report must immediately assess the resident and implement appropriate interventions as necessary". The policy fails to provide any definition of these interventions or any specific procedures to assist and support residents who have been abused or neglected or allegedly abused or neglected. The licensee failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [O.Reg. 79/10 s.96(a)]
3. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. The home's written policy fails to identify who will be informed of the investigation. The home's written policy does not identify the resident's SDM must be immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents identifies who will be informed of the investigation. [O.Reg. 79/10 s.96(d)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents
Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Inspector reviewed the home's documentation relating to investigation of incidents of abuse. The substitute decision maker's (SDM) of the residents involved were notified following the completion of the investigation. However, the SDM's were not notified within 12 hours of the licensee becoming aware of the allegations. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incidents of abuse or neglect of the resident. [O.Reg. 79/10 S.97(1)(b)]

Issued on this 17th day of October, 2011

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