



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 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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of inspection. Row 1: Sep 20, Oct 15, 2012; 2012_099188_0037; Critical Incident

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
MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Resident Care Coordinator, Registered Nursing Staff, Personal Support Workers, residents and families.

During the course of the inspection, the inspector(s) conducted the inspection in both the ELDCAP unit (facility #2755) and the Long Term Care unit (Facility #2932) by conducted a waik through of resident care areas, observed staff to resident interactions, reviewed health care records, staff education records, the home's investigation notes relating to allegations of abuse and neglect and reviewed various policies and procedures.

The following inspection Protoicols were used during this inspection:

- Personal Support Services
Prevention of Abuse, Neglect and Retailiation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.**
- 2. Every resident has the right to be protected from abuse.**
- 3. Every resident has the right not to be neglected by the licensee or staff.**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**
- 5. Every resident has the right to live in a safe and clean environment.**
- 6. Every resident has the right to exercise the rights of a citizen.**
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.**
- 9. Every resident has the right to have his or her participation in decision-making respected.**
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.**
- 11. Every resident has the right to,**
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,**
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.**
- 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.**
- 13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
- 14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.**
- 15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.**
- 16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.**
- 17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,**
 - i. the Residents' Council,**
 - ii. the Family Council,**
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,**
 - iv. staff members,**
 - v. government officials,**
 - vi. any other person inside or outside the long-term care home.**
- 18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.**
- 19. Every resident has the right to have his or her lifestyle and choices respected.**
- 20. Every resident has the right to participate in the Residents' Council.**
- 21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.**

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted that this report identifies a resident was neglected by staff. The licensee failed to ensure that the resident's right not to be neglected by the licensee or staff was fully promoted and respected. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(3)]

Additional Required Actions:

IPC - 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 ensuring the rights of residents are fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted that this report identifies a staff member used unsafe transferring techniques resulting in harm to the resident. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36]

Additional Required Actions:

IPC - 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 ensuring staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted that this report identifies allegations of neglect of a resident by staff and that "an investigation was initiated and is still underway". Inspector noted that the report was not amended or updated to include the results of the investigation upon its completion. The licensee failed to ensure that the results of the investigation were reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.23(2)]

WN #4: 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 report. Inspector noted that this report identifies allegations of neglect that were reported outside of the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of allegations of abuse of a resident by anyone or neglect of the resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]**

Issued on this 15th day of October, 2012

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

