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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 20, 2013	2013_139163_0023	S-000298-13	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 (2755)
825 McKINNON DRIVE, ESPANOLA, ON, P5E-1R4

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

DIANA STENLUND (163)

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): September 17, 2013

This inspection is in relation to both Espanola Nursing Home/LTC Unit License #2932 and Espanola Nursing Home/ELDCAP Unit License #2755.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered nursing staff and personal support workers.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed a Critical Incident report, observed staff to resident interactions and care, and reviewed resident health care records and home policies.

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

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #298 noting that they have a diagnosis of dementia and are recovering from a fractured hip. The resident's care plan indicates the use of a restraint in the form of a seat belt when in their wheelchair. Inspector reviewed the resident's health care record and was unable to locate documentation indicating that the resident was repositioned and released from the restraint at least every 2 hrs. Inspector interviewed registered staff about documentation requirements when a resident has a restraint. Staff confirmed to the inspector the home's lack of documentation to comply with this legislative requirement for resident #298. The licensee has not ensured that every use of a physical device to restrain resident #298 under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee has not ensured that the following are documented: Every release of the device and all repositioning. [s. 110. (7) 7.]

Issued on this 20th day of September, 2013

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

Original signed by:

Diana Stenlund