Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 22, 2024
Inspection Number: 2024-1248-0001
Inspection Type: District Initiated
Licensee: Espanola General Hospital
Long Term Care Home and City: Espanola General Hospital (operating as Espanola Nursing Home-Eldcap), Espanola

Lead Inspector	**Inspector Digital Signature**
Loviriza Caluza (687)	Loviriza P Caluza Digitally signed by Loviriza P Caluza Date: 2024.07.24 09:43:46 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15 to 18, 2024.

The following intake was inspected:

- One District Initiated intake related to Infection Prevention and Control (IPAC) and this was conducted concurrently with another inspection.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The home has failed to ensure that a resident's care plan was reviewed and revised when the resident's care needs has changed.

Rationale and Summary

A resident's room was observed with an isolation signage but, their electronic care plan record did not indicate their isolation precaution.

A review of the home's policy titled "Care Planning", indicated that, "The resident's care plan would be re-assessed at every quarterly care conference and/or whenever there was a change in the resident's condition".

Staff members and the IPAC Lead were interviewed and they stated that the resident was on isolation precaution The Director of Care (DOC) acknowledged that the resident's isolation precaution was not updated in their care plan, and it will be corrected.

Failure of the home to update a resident's plan of care to reflect their current isolation precautions has place other residents and staff members at risk. However, during the inspection, the resident's electronic care plan record was updated to reflect their current medical status.

Sources:
Resident observations; resident record reviews; review of the home's policy; interview with staff members, the IPAC Lead and the DOC.
[687]

Date Remedy Implemented: July 17, 2024

WRITTEN NOTIFICATION: Dining and Snack - appropriate furnishing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting

residents to eat.

The home has failed to ensure that appropriate seating was available for staff members who were assisting residents during dining service.

Rationale and Summary
A resident was being assisted with their meal by a PSW and there was no available dining room seating for staff members at that time.

A review of the home's policy titled "Dining & Meal Service", indicated that, "All resident dining areas will have comfortable furnishing to accommodate dining, and proper techniques to assist residents with eating".

The DOC was interviewed and acknowledged that staff members would require appropriate furnishing to assist residents during a meal service.

Failure of the home to provide appropriate seating for staff members who assist residents during meal service posed low risk to residents.

Sources
Dining room and resident observation; review of the home's policy, and interview with the DOC.
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