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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2015	2015_336620_0007	005164-15	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

Long-Term Care Home/Foyer de soins de longue durée

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

ALAIN PLANTE (620), CHAD CAMPS (609)

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): October 13, 14, 15, 16, 2015

This inspection was being conducted as a result of two critical incident (CI) notifications submitted to the Ministry of Health and Long Term Care (MOHLTC). On April 02, 2015, CI #2877-000008-15 was submitted to the MOHLTC, which reported an incident of resident to resident abuse. On July 14, 2015, CI #2877-0000015-15 was submitted, which related to a missing resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Assistant Director of Care (ADOC), one Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW), Residents, and a Resident substitute Decision Maker (SDM).

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Legendé 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 was observed by Inspector # 620 in a stimulating environment, in a common area, at a particular time of the day. A review of the resident's care plan revealed that the resident should have been in a low stimulus environment and in their room during the time they were observed by Inspector #620. The care plan also noted that the resident should have been redirected back to their room if they were not in their room during specific hours of the day.

An interview with staff member #103 revealed that the resident most often spent this time of day in a common area not designated in the care plan. When asked about why resident #001 was not in their room as specified in the care plan, the staff member stated that the resident was most often allowed to remain in the common area due to difficulty with redirection.

Two staff members were present and within view of the resident for 1.5 hours, and neither tried to redirect the resident to bed, as specified within the care plan, and should have. [s. 6. (7)]

Additional Required Actions:

VPC - 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 to ensure that the care set out in the plan of care will be provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that any policy the Licensee is required to have is complied with.

A critical incident (CI) related to a resident missing for less than three hours was submitted to the Director.

A review of the CI report revealed that resident #003 left the home on a leave of absence and was to return to the home the same day at 1600 hours; the resident had not returned by 1800 hours. At 1800 hours a staff member was made aware of the missing resident. At 1815 hours a voice mail message was left with the Substitute Decision Maker (SDM) for resident #003 informing the SDM of the missing resident. At 1840 hours the Administrator was called and informed of the situation, and instructed staff to contact the police. At 1900 hours the police located the resident.

A review of the home's policy titled, "Leave of Absence: Without a Responsible Party" last revised August 2015, instructed staff to call the destination of the resident to confirm the time of the resident's arrival back at the home. The call was to be made immediately when the resident did not return at the arranged time. The policy further instructed the staff member to initiate a Code Yellow if a resident was not located within one hour and to contact the Administrator.

An interview with the Administrator confirmed that it was the expectation of the home that the "Leave of Absence: Without a Responsible Party" policy was to be complied with, by staff; in the case of resident #003, the destination of the resident was not contacted immediately upon learning the resident was missing. The Code Yellow policy was not initiated. The Administrator was not contacted within one hour of becoming aware that resident #001 was missing, and should have. [s. 8. (1) (b)]

Additional Required Actions:

VPC - 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 to ensure that any policy the Licensee is required to have is complied with, to be implemented voluntarily.

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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that after a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition is reported to the Director no later than one business day following the occurrence of the incident.

A Critical Incident Report was submitted to the Director, related to a resident missing for less than three hours.

A review of the CI Report revealed that resident #001 went missing from the home.

An interview with the Administrator confirmed that there was a three day gap between the incident and the report submitted to the Director. The Administrator confirmed that it was the expectation of the home that the Director was to be informed of a missing resident within one business day of the occurrence; in the case of missing resident #003, this did not occur and should have. [s. 107. (3) 1.]

Additional Required Actions:

VPC - 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 to ensure that after a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition is reported to the Director no later than one business day following the occurrence of the incident, to be implemented voluntarily.

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.