



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

Sudbury Service Area Office  
159 Cedar Street Suite 403  
SUDBURY ON P3E 6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133

Bureau régional de services de  
Sudbury  
159 rue Cedar Bureau 403  
SUDBURY ON P3E 6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133

## Public Copy/Copie du public

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 2, 2015	2015_336620_0005	010044-15	Complaint

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### **Licensee/Titulaire de permis**

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

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

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

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

ALAIN PLANTE (620)

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## Inspection Summary/Résumé de l'inspection

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): October 13, 14, 15,16, 2015**

**This inspection is being conducted as a result of a complaint submitted to the Ministry of Health and Long Term Care on May 15, 2015, related to personal care at night time.**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Administrative Assistant to the Director of Care (AA), two Registered Nurses (RN), one Registered Practical Nurses (RPN), four Personal Support Workers (PSW) and one resident Substitute Decision Maker (SDM).**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**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>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**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. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident Report was submitted to the Ministry of Health and Long Term Care. The report outlined an incident which alleged staff neglected resident #001.

An interview with the SDM for resident #001 revealed that the home did not inform the SDM until one day following the incident.

An interview with the Administrator confirmed that it is the expectation of the home that the SDM was to be notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of neglect of the resident. In the case of the allegations of neglect by staff of resident #001, the SDM should have been notified, and this did not occur. [s. 97. (1) (b)]



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**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.**