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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 28, 2016	2016_269627_0016	013273-16, 016604-16, 016635-16, 016636-16	Follow up

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

SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 20-24, 2016.

This Follow up Inspection is related to the following compliance orders issued to the home:
- Plan of Care, RN staffing,
- Duty to protect, mandatory reporting of abuse and the home's abuse policy.

A Critical Incident inspection # 2016_269627_0015, and and a Complaint inspection 2016_269627_0016, were conducted concurrently.

The Inspector(s) conducted a daily walk through resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staff training records, staffing schedules, policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, family members and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_282543_0006	627
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2016_463616_0004	627
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2016_282543_0006	627
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2016_282543_0006	627
O.Reg 79/10 s. 37.	WN	2016_463616_0004	627
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2016_463616_0004	627
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2016_463616_0004	627
O.Reg 79/10 s. 96.	CO #003	2016_282543_0006	627

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 the care set out in the plan of care was provided to an identified resident as specified in the plan.

Inspector #627 reviewed the plan of care for an identified resident as part of the follow up inspection.

During the review of the resident's plan of care, Inspector #627 noted that the resident was receiving a specific type of care. A review of the Doctor's orders revealed the following:
A certain type of medical treatment to be administered in specific circumstances.

A review of the Medication Administration Record (MAR), failed to reveal the certain type of medical treatment.

A review of the progress notes revealed two entries which identified that the resident was demonstrating the specific circumstances described by the Doctor, and required the treatment on two different occasions.

During an interview with the Inspector, an RPN stated that care plans were updated by the RNs at 1500 hours, daily. This included reviewing the electronic care plans, the paper copy of the care plan and the Kardex. This also included transcribing orders to the MAR, which included the type of medical treatment to be administered in specific circumstances to the identified resident.

During an interview, an RN stated that the resident had two specific circumstances when the certain type of medical treatment should have been administered. The RN confirmed that the certain type of medical treatment had not been administered to the identified resident.

During an interview with the Inspector, the Administrator/Director of Care (Admin/DOC) stated that the certain type of medical treatment should have been provided to the identified resident in those specific circumstances. The Admin/DOC confirmed that the care set out in the plan of care was not provided as specified in the plan. [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 is provided to an identified resident as specified in the plan, to be implemented voluntarily.

Issued on this 30th day of September, 2016

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

Original report signed by the inspector.