Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 5th, 6th, and 7th, 2010	2011_188_2877_05Jan114957	Complaint Inspection Log # S-00115, IL-14231-SU Log # S-00618, IL-15254-SU Log # S-00650, IL-15307-SU

Licensee/Titulaire
St. Joseph's General Hospital, Elliot Lake, 70 Spine Road, Elliot Lake, P5A1X2, F- 705-848-6239

Long-Term Care Home/Foyer de soins de longue durée
St. Joseph's Manor, 70 Spine Road, Elliot Lake, P5A 1X2, F-705-848-2596

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm 188

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct complaint inspections.

During the course of the inspection, the inspector spoke with: the Director of Care (DOC), Registered Nursing staff, Personal Support Workers (PSW), Recreation staff, residents involved in the complaints, various residents currently residing in the home, and family members of residents currently residing in the home.

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed the care of residents named in complaints, observed the care of other residents currently residing in the home, and reviewed the following:

- Policies and procedures related to restraints
- Health care records of residents named in the complaints and other residents currently residing in the home
- Health care records of residents discharged from the home September 1, 2010 until November 30, 2010.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraints
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection. The following action was taken:

10 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.23(2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Findings:

1. The inspector reviewed a document titled "Resident/Family/Public compliment and/or Complaint". This document described allegations of abuse. The results of this investigation where not reported to the Director. The licensee failed to report to the Director the results of this investigation.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)1 Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the residents individuality and respects the resident's dignity.

Findings:

1. The inspector observed a resident walking and noted a strong odour of urine which was determined to be coming from the resident. The back side and legs of the resident's pants were visibly wet. This resident was directed back to the resident's room by a staff member. The resident was later observed lying in bed wearing the same visibly wet pants and a strong odour remained. Continence care had not been provided by the staff member. The licensee failed to ensure that the resident was treated with courtesy and respect and in a way that respects the resident's dignity.

2. The inspector observed a resident sitting in front of a table in their wheelchair. The wheelchair brakes were applied. The resident was attempting to foot propel but was unable due to the application of the wheelchair brakes. This resident was left sitting at the table for an extended period of time. The licensee failed to ensure that the resident was treated with courtesy and respect and in a way that respects the resident's dignity.

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WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.

Findings:

1. The inspector observed a resident with a restraint applied to their wheelchair. The health care record of the resident did not identify the significant risk to that resident or another person if the restraint was not used. The licensee failed to identify the significant risk the resident or another person would suffer if the resident was not restrained.

2. The inspector observed a resident with a restraint applied to their wheelchair. No alternatives to restraining this resident were considered prior to restraining the resident. The licensee failed to consider alternatives to restraining a resident and to determine if they are effective, prior to restraining the resident.

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WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)c Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The inspector reviewed the plan of care for a resident. The plan of care identifies that the resident is able to walk independently and later identifies that the resident requires assistance and supervision to walk. It was observed that this resident was in a wheelchair and unable to walk. This does not set out clear direction to staff on how the resident is able to walk. The licensee failed to ensure the written plan of care for the resident sets out clear directions to staff and others who provide direct care to the resident.

2. The inspector reviewed the plan of care for a resident. The plan of care identifies that the resident uses only a walker and later identified that the resident uses only a wheel chair. This is contradicting information regarding the assistive devise used by this resident. The licensee failed to ensure the written plan of care for the resident sets out clear directions to staff and others who provide direct care to the resident.

3. The inspector reviewed the plan of care for a resident. The plan of care identifies that this resident is unable to ambulate without full staff assistance and also identifies that the resident is completely independent with ambulation. This is contradicting information regarding how much assistance this resident requires. The licensee failed to ensure the written plan of care for the resident sets out clear direction to staff and others who provide direct care to the resident.

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WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. The inspector observed a resident walking without proper footwear. The plan of care for this resident

identifies that the resident is to always wear proper footwear. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

2. Inspector observed a resident without hearing aids. The plan of care for this resident indicates that staff is to assist the resident to apply the hearing aids every morning. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
3. The plan of care for a resident indicates the resident requires assistance to toilet following all meals. The inspector observed that this resident was not assisted to toilet following a meal service. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
4. The plan of care for a resident indicates that the resident is to be directed to use the toilet prior to meals. The inspector observed that this resident was not directed to use the toilet prior to a meal service. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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WN #6: The Licensee has failed to comply with O. Reg. 79/10, s. 110(2)4 That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)

Findings:

1. The inspector observed a resident with a restraint applied to their wheelchair that was not released over a time period greater than two hours. The resident was also not repositioned during this same time period. The licensee failed to release the resident from the physical device and reposition the resident at least once every two hours.

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WN #7: The Licensee has failed to comply with O. Reg. 79/10, s. 129(1)a Every licensee of a long-term care home shall ensure that, a) drugs are stored in an area or a medications cart, (ii) that is secure and locked.

Findings:

1. The inspector observed the medication cart stored behind the second floor nursing station. The medication cart was not locked and the inspector opened a drawer and observed multiple blister packs of medication, including several blister packs of Warfarin. No staff members were present at the nursing desk as change of shift report was taking place in a separate room. A resident was seated in the common lounge area near the nursing desk. The licensee failed to ensure that drugs are stored in a medication cart that is secure and locked.

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WN #8: The Licensee has failed to comply with O. Reg. 79/10, s.17(1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times

Findings: 1. The inspector observed a resident sitting in their room. The wireless call badge was behind the resident and not accessible to this resident. The licensee failed to ensure that the resident-staff communication and response system is easily accessible at all times. 2. The inspector observed a resident sitting in their room. This resident was unable to reach the wireless call badge from the chair they were sitting in. The licensee failed to ensure the resident-staff communication and response system is easily accessible at all times. 3. The inspector observed a resident in their room sitting in their wheelchair. The wireless call badge was attached to the bedside table out of the resident's reach. The licensee failed to ensure the resident-staff communication and response system is easily accessed at all times. 4. Inspector observed ten of the eleven residents sitting in the lounge were not wearing wireless call badges. The licensee failed to ensure that the resident-staff communication and response system is easily accessible at all times.	
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WN #9: The Licensee has failed to comply with O. Reg. 79/10, s. 37(2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids.	
Findings: 1. The inspector observed a resident without hearing aids. It was identified in the resident's plan of care that this resident requires staff assistance to apply hearing aids. The licensee has failed to ensure that each resident receives assistance to use personal aids if required.	
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WN #10: The Licensee has failed to comply with O. Reg. 79/10, s. 51(2) Every licensee of a long-term care home shall ensure that, c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence	
Findings: 1. The inspector observed a resident who was not provided assistance to maintain continence. It was identified in the resident's plan of care that this resident is unable to toilet without staff assistance. The licensee has failed to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.	
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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** [signature]
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). February 7, 2011