Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue 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


## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 28, 2019 | 2019_669642_0015 (A2) | 008075-19 | Complaint |

### 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

Amended by KEARA CRONIN (759) - (A2)

### Amended Inspection Summary/Résumé de l'inspection modifié

**The licensee has been granted an extension to allow the home to achieve sustainable compliance.**

**Issued on this 28th day of November, 2019 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
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| Nov 28, 2019 | 2019_669642_0015 (A2) | 008075-19 | Complaint |

### Licensee/Titulaire de permis

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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

Amended by KEARA CRONIN (759) - (A2)

## Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): August 12-16, 2019**

**The following intake were inspected during this Complaint inspection:**

**- One Log, related to concerns about alleged short staffing in the home and resident's safety.**

**A Critical Incident System (CIS) Inspection, 2019_669642_0016, was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with ththe Administrator/Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Aid, Human Resources Generalist, Personal Support Workers (PSWs), and residents.**

**The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.**

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

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

**1 WN(s)**
**0 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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. 8. Nursing and personal support services**

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

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was at least one registered nurse, who was both an employee of the licensee, and a member of the regular nursing staff of the home, that was on duty and present in the home at all times, except as provided for in the regulations.

A complaint was submitted to the Director which outlined concerns that the home was working short staffed, the complainant was worried about resident safety.

Inspector #679 interviewed the Administrator/Director of Care (DOC) about concerns related to short staffing. During the telephone interview the inspector reviewed the home's staffing hours with the Administrator/DOC, who identified that the home was having issues with registered nurse (RN) staffing; the home was not meeting the requirements of the legislation, and presently there was not an RN on site in the home 24 hours.

Inspector #642 requested a copy of the last three months of the nursing schedule, to review the periods that an RN of the regular nursing staff were on site in the home. The identified document was provided and reviewed, and pay periods were in two week increments (or 28 RN shifts). The RN day shift hours (hrs) were, 0700 -1900hrs, and RN night shift hours were from 1900 to 0700hrs. The documents detailed how the home failed to have an RN on-site for 81 of 168 shifts or 48 per cent of the review period.

Inspector #642 reviewed the staffing schedule while in the home from a specific date to a specific date; there was no night RN on all five night shifts, and no RN on site for one day shift. As confirmed in a subsequent interview with the Administrator/DOC.

The Inspector interviewed registered practical nurses (RPN's), #102, #103, #104, and RN #110, they stated there was not an RN on duty in the home 24 hours a

day, and there was no RN on at nights, and sometimes the weekends. The home had placed extra RPN's on duty, and a RN would be on call, but not in the home.

In an interview with the Administrator/DOC, they identified that they were not in charge of the recruiting of RN's in the long-term care home, since the home was part of the hospital; the hospital oversaw the recruitment. The Administrator/DOC stated they had been short RN's for over three months and understood that the term "emergency" (identified in the Long Term-Care Act, 2007), meant an unforeseen situation of a serious nature that prevented a registered nurse from getting to the Long-Term Care home, (s. 45 (2) and, understood that it did not apply to their situation. The Administrator/DOC acknowledged that the shortage of RN's had left the night shifts and some of the day shifts, without an RN on-site in the home; and they understood that this did not follow the legislation requirement. [s. 8. (3)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)**
**The following order(s) have been amended: CO# 001**

**Issued on this 28th day of November, 2019 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by KEARA CRONIN (759) - (A2) |
| **Inspection No. / No de l'inspection :** | 2019_669642_0015 (A2) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 008075-19 (A2) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Nov 28, 2019(A2) |
| **Licensee / Titulaire de permis :** | St. Joseph's General Hospital Elliot Lake<br>70 Spine Road, ELLIOT LAKE, ON, P5A-1X2 |
| **LTC Home / Foyer de SLD :** | St. Joseph's Manor<br>70 Spine Road, ELLIOT LAKE, ON, P5A-1X2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Cynthia Farquhar |

To St. Joseph's General Hospital Elliot Lake, you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The Licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically the licensee must:
a) Ensure there is at least one registered staff nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was at least one registered nurse, who was both an employee of the licensee, and a member of the regular nursing staff of the home, that was on duty and present in the home at all times, except as provided for in the regulations.

A complaint was submitted to the Director which outlined concerns that the home was working short staffed, the complainant was worried about resident safety.

Inspector #679 interviewed the Administrator/Director of Care (DOC) about concerns related to short staffing. During the telephone interview the inspector reviewed the home's staffing hours with the Administrator/DOC, who identified that the home was having issues with registered nurse (RN) staffing; the home was not meeting the requirements of the legislation, and presently there was not an RN on site in the home 24 hours.

Inspector #642 requested a copy of the last three months of the nursing schedule, to review the periods that an RN of the regular nursing staff were on site in the home. The identified document was provided and reviewed, and pay periods were in two week increments (or 28 RN shifts). The RN day shift hours (hrs) were, 0700-1900hrs, and RN night shift hours were from 1900 to 0700hrs. The documents detailed how the home failed to have an RN on-site for 81 of 168 shifts or 48 per cent of the review period.

Inspector #642 reviewed the staffing schedule while in the home from a specific date to a specific date; there was no night RN on all five night shifts, and no RN on site for one day shift. As confirmed in a subsequent interview with the Administrator/DOC.

The Inspector interviewed registered practical nurses (RPN's), #102, #103, #104, and RN #110, they stated there was not an RN on duty in the home 24 hours a day, and there was no RN on at nights, and sometimes the weekends. The home had placed extra RPN's on duty, and a RN would be on call, but not in the home.

In an interview with the Administrator/DOC, they identified that they were not in charge of the recruiting of RN's in the long-term care home, since the home was part of the hospital; the hospital oversaw the recruitment. The Administrator/DOC stated they had been short RN's for over three months and understood that the term "emergency" (identified in the Long Term-Care Act, 2007), meant an unforeseen situation of a serious nature that prevented a registered nurse from getting to the Long-Term Care home, (s. 45 (2) and, understood that it did not apply to their situation. The Administrator/DOC acknowledged that the shortage of RN's had left the night shifts and some of the day shifts, without an RN on-site in the home; and they understood that this did not follow the legislation requirement.

The severity of this issue was determined to be a level 3 as actual risk. The scope of the issue was a level 2, as it was identified as a pattern. The home had a level 2 compliance history, with one or more unrelated non-compliances.

(642)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 31, 2020(A2)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  28th  day of November, 2019 (A2)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by KEARA CRONIN (759) - (A2)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Service Area Office / Bureau régional de services :** Sudbury Service Area Office