Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 3, 4, 5, 8, 2011	2011_057163_0006	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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Accountant, finance department staff, registered nursing staff, personal support workers (PSWs), Activity Assistant, Administrative Assistant, and residents.

During the course of the inspection, the inspector(s) walked through the home areas on 1st floor, observed resident care and staff interactions with residents, watched lunch and dinner meals on 1st floor.

The following Inspection Protocols were used in part or in whole during this inspection:

Dignity, Choice and Privacy

Recreation and Social Activities

Trust Accounts

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits sayants :

1. The licensee has failed to ensure that the written plan of care for residents sets out clear directions to staff and others who provide care to a resident. Inspector reviewed the "Kardex" document for a resident. It indicates that this resident presents a risk to themselves regarding an identified behaviour. There are no clear directions or interventions written for staff to assist with addressing this behaviour.[s. 6(1)(c)]
2. Inspector reviewed the "Resident Care Plan" document for a resident. This written document does not provide clear direction for staff to care for the resident. The section of "Activities Spiritual" discusses repositioning and assistance with ADLs however does not discuss any clear direction for staff related to "Activities Spiritual". The section of "Activities Arts" on the "Resident Care Plan" discusses ability to transfer safely, however it does not provide any clear direction for staff with regards to "Activities Arts".[s.6(1)(c)]
3. The directions for staff regarding dental care for a resident are not clear. The "Resident Care Plan" document (dated July 01/11) - "Dental- apply polygrip to lower denture every am". The "Care Plan Review" document dated July 9/11 - "has not been wearing dentures, staff does mouthcare". There are not clear written directions for staff providing dental care for this resident. [s.6(1)(c)]

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 the written plan of care for all residents, provides clear directions to staff and others who provide direct care to the resident , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts
Specifically failed to comply with the following subsections:

s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).

Findings/Faits sayants :

1. The licensee has failed to obtain written authorization to pay the licensee for charges from resident's trust accounts. A new phone charge of $7.91 as of Aug 01/11 was charged to a resident's trust account without written authorization from the resident's POA, this was confirmed by a staff member from Accounts Receivable on Aug 03/11.

2. The inspector interviewed the Accountant. The accountant confirmed that money was withdrawn from a resident's trust account that did not have written authorization from this resident's POA. These unauthorized withdraws include an escort cost of $30 Feb 16/10, taxi service $20 each on March 2/10 and Jan 28/10, and taxi service $16 Jan 12/10.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 261. Statements

Findings/Faits sayants :

1. The licensee has failed to provide a resident/SDM with itemized trust account statements. A resident's 2010 trust account statement indicates that a "petty cash" amount of $81 was listed on the statement on May 4/10. Discussion with the Accountant on Aug 3/11 indicated that this "petty cash" amount of $81 was actually made up of several charges on different days between January and April 2010. The accountant reported that the charges were not itemized as required on the trust account statement as to the items/services purchased with the $81.

Issued on this 9th day of September, 2011

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

Diana Stenlund