Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: November 3, 2023
Inspection Number: 2023-1362-0005
Inspection Type: Proactive Compliance Inspection
Licensee: St. Joseph's General Hospital Elliot Lake
Long Term Care Home and City: St. Joseph's Manor, Elliot Lake

Lead Inspector	**Inspector Digital Signature**
Amy Geauvreau (642)	Amy Geauvreau Digitally signed by Amy Geauvreau Date: 2023.11.17 16:00:07 -05'00'

Additional Inspector(s)
Chad Camps (609)
Lisa Moore (613)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):

August 28-31, 2023, and September 1, 2023.

The following intake(s) were inspected:

- Intake: #00095275 - PCI Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
During the initial tour, no abuse policy was posted in the home. The Administrative Assistant (AA) described how the abuse policy used to be posted. On August 31, 2023, the home's abuse policy was posted on the main floor. The home's failure to post their policy to promote zero tolerance of abuse and neglect of residents presented minimal risk to residents.

Sources: Inspector's observations; The home's policy titled "Zero-Tolerance of Abuse and Neglect"; and interviews with the AA. [609]

Date Remedy Implemented: August 31, 2023.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (r)

The licensee has failed to ensure that an explanation of the whistle-blowing protections afforded under section 30 of the Act was posted.

Rationale and Summary
During the initial tour, no explanation of the whistle-blowing protections under the Act was posted in the home. The AA described how the whistle-blowing protections used to be posted but had since been removed. On August 31, 2023, the whistle-blowing protections under the Act were posted on the home's main floor. The home's failure to post an explanation of the whistle-blowing protections under the Act presented minimal risk to residents.

Sources: Inspector's observations; and interviews with the AA. [609]

Date Remedy Implemented: August 31, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
During the initial tour, no visitor policy was posted in the home. The AA described how the visitor policy used to be posted but had since been removed. On August 31, 2023, the home's Visitor policy was posted on the main floor. The home's failure to post the home's visitor policy presented minimal risk to residents.

Sources: Inspector's observations; and Interviews with the AA. [609]

Date Remedy Implemented: August 31, 2023.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee has failed to ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary
Interviews with the Resident and Family Council representatives identified, it was unclear when the last yearly survey for the residents, families and caregivers was completed for the home. On review of the Long-Term Care home's survey titled, "St. Joseph's Manor Family Satisfaction Survey", the last survey completed was for 2021.

The Director of Care (DOC) stated that there was no Family or Resident survey completed for 2022. There was minimal impact to the residents, when the home failed to ensure, that at least annually, the residents, their families and caregivers completed the survey.

Sources: The home's survey titled, "St. Joseph's Manor Family Satisfaction Survey", the last survey completed was for 2021; and interviews with Resident and Family Council representatives; and the Administrative Assistant, and the DOC. [642]

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the home's hairdressing studio was kept closed and locked when not being supervised by staff.

Rationale and Summary
During the initial tour, chemicals were found inside the home's hairdressing studio which was found unlocked and unattended by staff. A Registered Practical Nurse indicated that residents do pass by the hairdressing studio and then proceeded to lock the hairdressing studio after they verified the door should have been locked.

The home's failure to ensure that the hairdressing studio was locked when not attended presented moderate risk to residents.

Sources: Inspector's observations; interviews with an RPN; and the Administrator. [609]

WRITTEN NOTIFICATION: Air temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

The licensee has failed to ensure that the Long-Term Care home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
Between one month to another month in 2023, a number of residents' room temperature logs, found certain room's had multiple temperature readings below 22 degrees Celsius, with some readings as low as 19.6 degrees Celsius. The home's policy failed to indicate that the home's temperature was to be maintained at a minimum of 22 degrees.

The Building Services Manager acknowledged they did not currently have a protocol for staff to utilize when the temperature reading was below the required minimum. The home's failure to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius presented moderate risk of harm to residents.

Sources: The home's policy titled "Heat Wave: Contingency Plan" last revised May 2018; Internal temperature readings between one month to another month in 2023; and an interview with the Building Services Manager. [609]

WRITTEN NOTIFICATION: General requirements for Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

1. The licensee has failed to ensure that the Nutrition and Hydration program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
A review of the licensee's policy titled, "Nutrition and Hydration Program" (NUM VI-45) indicated that the policy was last reviewed and updated in 2016. The Director of Care verified this was the home's most current policy and indicated the nutrition and hydration program policy required updating.

Sources: Nutrition and Hydration Program policy (NUM VI-45) last updated in 2016; and interview with the DOC. [613]

Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

2. The licensee has failed to ensure that the Falls Prevention and Management program, was evaluated and updated at least annually, in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home's program, "Fall Prevention and Management Program", was last revised, in 2018. The DOC and the Fall's Lead RPN confirmed that the Falls program was not evaluated or updated since 2018 and should have been. There was minimal risk to the residents, when the home failed to ensure, that at least annually, the home's falls prevention and management program was evaluated and updated.

Sources: The home's program titled, "Falls Prevention and Management Program," last revised in 2018; and interviews with the Falls Lead RPN and DOC. [642]

3. The licensee has failed to ensure that the home's pain program was evaluated and updated at least annually in accordance with evidence-based practices.

Rationale and Summary
The DOC verified that the pain program was outlined in the home's policy titled "Pain Assessment Management Program". Despite the policy's requirement that the program was evaluated annually, the DOC acknowledged no evaluation had been conducted since 2016. The home's failure to ensure that the home's pain program was evaluated and updated annually presented low risk of harm to residents whose pain was managed under an outdated program.

Sources: The home's pain program titled, "Pain Assessment Management Program," last revised in 2016; and an interview with the DOC. [609]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)

The licensee has failed to ensure that the monthly surveillance to detect trends, for the purpose of reducing the incidence of infection and outbreaks was being completed and documented.

Rationale and Summary
According to s. 3. of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, the licensee was to ensure that symptom screening information was gathered as outlined under O. Reg. 246/22 s. 102. (9) and was then analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The Administrator/IPAC Lead stated that they could not provide the required monthly surveillance documents. Failing to ensure that monitoring of monthly surveillance to detect potential trends, for the purpose of reducing the incidence of infection and outbreaks, placed residents at a minimal risk.

Sources: The IPAC Standard for LTCHs, dated April 2022; and interviews with Administrator/IPAC Lead, and other staff. [642]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
The DOC indicated that that interdisciplinary team members were all new to their positions and they were aware that they were required to meet quarterly; however, the meetings had not occurred.

The Administrator identified that they did not have written documentation to demonstrate that an evaluation of the medication system had occurred. The failure of the home not having a current interdisciplinary team meeting quarterly to evaluate the effectiveness of the medication management system resulted in low risk and impact to the residents.

Sources: Interviews with Administrator and DOC; and no written documentation of an evaluation of the medication management system**.** [613]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3)

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents that occurred in the home since the time of the last review.

Rationale and Summary
The home was unable to provide a written record of a quarterly review of all medications incidents that had occurred in the home. The Administrator and DOC both identified that they did not have a written record to demonstrate that a review had been completed on the medication incidents. The failure of the home's interdisciplinary team to meet quarterly to review all of the medication incidents that occurred in the home resulted in low risk and impact to the residents.

Sources: Interviews with Administrator and DOC; and no written documentation of a quarterly review of all medication incidents.[613]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiate Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to prepare a report on the Continuous Quality Improvement (CQI) initiative for the home for each fiscal year no later than three months after the end of the fiscal year and subject to section 271, shall publish a copy of each report on its website.

Rationale and Summary

The home was unable to provide a final written report on the 2022-2023 CQI initiative for the home, and it was not published on the home's website.

The DOC acknowledged that the home had not prepared a CQI initiative report for the 2022-2023 fiscal year as required. There was minimal risk to residents when the home did not prepare the CQI initiative report.

Sources: Review of the home's SJM Quality Improvement Indicators, Agenda for the Quality Improvement Committee, and Quality Improvement Program policy; and an interview with the Administrator, DOC, AA and Resident and Family Council representative. [642]

COMPLIANCE ORDER CO #001 Accommodation services

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Write a clear description of how and to who staff are to immediately record and report any missing/malfunctioning components of the communication-response system;

b) Train all direct care staff on the home's new written description;

c) Develop a written process that clearly identifies who, how and in what timelines, IT staff will take action to correct the communication-response system;

d) Conduct weekly written audits of the home's communication-response system and take immediate action to correct any identified components;

e) Continue to conduct and maintain records of the audits if any missing/malfunctioning components are identified;

f) Conduct a documented review to ensure that there are a sufficient number of pagers for all direct care staff. Ensure corrective action is taken to address any gaps in the current supply;

g) Conduct a written inter-disciplinary analysis to determine if continued use of the home's communication-response system poses an ongoing risk(s) to the safety of residents; and

h) Implement corrective action to mitigate any identified risks.

Grounds
The licensee has failed to ensure that the home's communication and response system was maintained in a safe condition and in a good state of repair.

Rationale and Summary

a) During the initial tour, malfunctioning call bell lights were identified by the Inspector.

The next day, the Inspector found additional rooms that had malfunctioning call bell lights.

b) A previous communication-response system audit provided by the home, found that identified rooms did not have functioning call bell lights.

The home failed to provide any documentation of actions taken to address the malfunctioning system at the time.

c) Despite the home's policy which required staff have the appropriate pager assigned to them, at no time during the inspection was a staff member seen wearing/holding a pager.

The Administrator acknowledged that they were aware that some of the pagers had gone missing.

The DOC verified that as a result, there were times when staff would not know where the call was coming from.

d) The home's malfunctioning communication-response system.

The home's failure to ensure that the home's communication and response system was maintained in a safe condition and in a good state of repair presented high risk of harm to residents.

Sources: Inspector observations; VERSUS Audit report; The home's maintenance request logs; The home's policy titled "Versus System Audit Control"; Email correspondence; Interviews with the Buildings Manager; IT staff; DOC and Administrator. [609]

This order must be complied with by January 12, 2024.

COMPLIANCE ORDER CO #002 Communication and response system

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a written plan to deactivate or otherwise disable the home's communication-response system's ability to cancel calls from anywhere other than at the point of activation.

Grounds
The licensee has failed to ensure that the home's resident-staff communication and response system allowed calls to be cancelled only at the point of activation.

Rationale and Summary

During the initial tour of the home, a PSW demonstrated how they were able to cancel activated call bells from resident rooms at the nursing station.

The DOC verified that they were aware that calls could be cancelled at the nursing station.

The home's failure to ensure that the home's resident-staff communication and response system could only be cancelled at the point of activation presented high risk to residents whose calls for assistance could be cancelled at the nursing station.

Sources: Inspector's observations; The home's policy titled "Versus System Audit Control"; Interviews with IT and the DOC. [609]

This order must be complied with by January 12, 2024.

COMPLIANCE ORDER CO #003 Cooling requirements

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Conduct and keep a record of an interdisciplinary review of the home's heat related illness prevention and management plan, ensuring that the plan is based on current evidence-based practices; and

b) Develop and implement a plan to communicate the revised plan to staff and others based on the requirements under the Act.

Grounds
The licensee has failed to ensure that the heat related illness prevention and management plan for the home was evaluated and updated, at a minimum, annually in accordance with evidence-based practices.

Rationale and Summary

a) The Administrator verified that the home's heat related illness prevention and management plan was titled "Heat Wave: Contingency Plan". The plan did not require an annual evaluation in accordance with evidence-based practices be conducted annually and was last evaluated six years ago.

b) Pursuant to Ontario Regulation (O. Reg.) 246/22 section 23 (4) the home was to implement their heat related illness prevention and management plan:
i) Every year during the period from May 15 to September 15,
ii) Any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home was located was 26 degrees Celsius or above at any point during the day, and
iii) Anytime the temperature in an area in the home measured by the licensee in accordance with

subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

The home's heat related illness prevention and management plan indicated that the guideline would be implemented between June to September. There was no mention to implement the plan if the outside temperature forecasted by Environment and Climate Change Canada was 26 degrees or above or at any time the temperature in an area in the home measured reached 26 degrees or above, for the remainder of the day and the following day.

c) Pursuant to (O. Reg.) 246/22 section 23 (2) (e) the home's heat related illness prevention and management plan required a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council, the Family Council, if any, and others where appropriate.

The home's heat related illness prevention and management plan failed to contain any protocol for appropriately communicating the plan to anyone and failed to mention volunteers, substitute decision-makers, visitors, the Residents' Council, the Family Council, if any, and others where appropriate were to be informed of the plan.

The Administrator also verified that staff were not trained in the heat related illness prevention and management plan that was provided by the home.

The home's failure to ensure that their heat related illness prevention and management plan was evaluated and updated, at a minimum, annually in accordance with evidence-based practices presented high risk to residents.

Sources: The home's policy titled "Heat Wave: Contingency Plan"; and an interview with the Administrator. [609]

This order must be complied with by December 3, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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