

**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**

<b>Report Issue Date:</b> February 15, 2024	
<b>Inspection Number:</b> 2024-1362-0001	
<b>Inspection Type:</b> Complaint Critical Incident Follow up	
<b>Licensee:</b> St. Joseph's General Hospital Elliot Lake	
<b>Long Term Care Home and City:</b> St. Joseph's Manor, Elliot Lake	
<b>Lead Inspector</b> Lisa Moore (613)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Steven Naccarato (744)	

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 29-31, 2024, and February 1-2, 2024.

The following intake(s) were inspected:

- Intake related to accommodation services.
- Intake related to the communication and response system.
- Intake related to cooling requirements.

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- Intake related to the provision of skin and wound care.
- Intake related to a resident fall resulting in an injury.
- Intake related to an enteric outbreak.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1362-0005 related to FLTCA, 2021, s. 19 (2) (c) inspected by Lisa Moore (613)

Order #002 from Inspection #2023-1362-0005 related to O. Reg. 246/22, s. 20 (c) inspected by Lisa Moore (613)

Order #003 from Inspection #2023-1362-0005 related to O. Reg. 246/22, s. 23 (3) inspected by Lisa Moore (613)

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

Resident Care and Support Services  
Skin and Wound Prevention and Management  
Safe and Secure Home  
Infection Prevention and Control  
Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

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.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan.

**Rationale and Summary:**

A resident was to have a safety device on their ambulation device.

The resident had a fall and was injured as a result of their safety device not being applied on their ambulation device.

A Personal Support worker (PSW) verified that a safety device was to be applied to the resident's ambulation device at all times and that it was not applied at the time of the fall.

The home's failure to ensure that the safety device was applied on the resident's ambulation device resulted in moderate harm to the resident.

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**Sources:** Critical Incident System (CIS) report; Resident's electronic health record; Risk management incident report; Interview with a PSW and other staff. [744]

## **WRITTEN NOTIFICATION: Falls Prevention and Management**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's fall prevention and management program when a resident had a fall.

In accordance with O. Reg. 246/22, s. 11. (1) (b), the licensee must ensure that the fall prevention and management program was developed and implemented in the home and that it was complied with.

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Specifically, staff did not comply with the following of the licensee's Post Fall Management policy, which was part of the fall prevention and management program. The licensee's policy identified that for any unwitnessed fall, the 48-hour Post Fall Observation Log was to be initiated.

**Rationale and Summary:**

A resident had an unwitnessed fall and sustained an injury.

The Director of Care (DOC) confirmed that there was no record of a 48-hour Post Fall Observation Log completed for the resident.

The home's failure to ensure that the Post Fall Management policy was followed was a low risk to the resident.

**Sources:** Critical Incident System (CIS) report; The home's Fall Prevention and Management Program, Resident's electronic health record; Risk management incident report; Interview with the DOC and other staff. [744]

**WRITTEN NOTIFICATION: Skin and Wound Care**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,  
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,  
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

**Rationale and Summary:**

There was no documentation on the home's electronic documentation system to indicate that weekly skin assessments had been completed by registered staff during a specific time for a resident who exhibited altered skin integrity.

A Registered Nurse (RN) verified that the skin assessments should have been completed weekly and that they had not been done for a particular resident over a period of weeks.

The home's failure to ensure that weekly wound assessments was completed for a resident was minimal risk to the resident.

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**Sources:** Complaint intake; Resident's electronic health records; Skin & Wound care program; Interview with a RN and other staff.

[744]



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

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