Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of inspector (ID #) / Nom de l'inspecteur (No) :	DIANA STENLUND (163)
Inspection No. / No de l'inspection :	2012_139163_0037
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Oct 26, 30, 31, Nov 1, 2, 5, 6, 7, 9, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN CLAYTON

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that resident #1087 is provided the proper beverages at meals and snacks as directed in their plan of care.

Grounds / Motifs :

1. Two previous WNs have been issued under s.6(7).
The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan.
Resident's #1087 health care record indicates a history of abnormal blood work. Inspector interviewed staff member S-001 who reported that the plan of care for resident #1087 requires that certain foods be avoided as a result of their health history. This was confirmed by the inspector in the review of resident's #1087 health record. Resident #1087 was observed at lunch meal service. Inspector observed that this resident was not provided the diet as outlined in their plan of care. Staff member S-006 confirmed to the inspector that they had made an error with regards to providing the diet as specified in resident's #1087 plan of care. [LTCHA,2007, S.O.2007,c. 8, s. 6 (7)]. (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must ensure that drugs are stored in an area or medication cart that is secure and locked and that controlled substances are stored in a separate, double-locked cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Grounds / Motifs :

1. The licensee has not ensured that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.
On Nov. 01, 2012 on the second floor, the inspector observed that the box within the medication cart used to store controlled substances had a broken lock. A discussion with supervisory staff members S-002 and S-003 on Nov. 01, 2012 confirmed that the lock on the box (within the medication cart) used to store controlled substances was broken and that they were not clear on how long it had been broken. [O. Reg. 79/10, s. 129 (1)(b)]. (163)
2. The licensee has not ensured that drugs are stored in an area or a medication cart that is secure and locked.
A Critical Incident submitted by the licensee reports that resident #242 gained access to a drug-related product where drugs and drug-related supplies are stored. Supervisory staff member S-003 confirmed that the lock on the storage cupboard was broken when resident #242 gained access to a drug-related product. [O. Reg. 79/10, s. 129 (1)(a)(ii)] (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2012

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 or by fa

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance 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 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:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of November, 2012

Signature of inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

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

Ontario

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Oct 26, 30, 31, Nov 1, 2, 5, 6, 7, 9, 2012	2012_139163_0037	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/Director of Care, registered nursing staff, personal support workers (PSWs), registered dietitian (RD), food service supervisor, maintenance worker, pharmacy provider representative, residents and family members.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed health care records, observed meal service, reviewed the home's policies and procedures, reviewed critical incident reports and observed staff to resident care and interactions.

During the course of the inspection the following logs were reviewed:
S-002176-12
S-001759-11
S-001087-12
S-000277-12
S-001182-12
S-001231-12
S-000278-12
S-000611-12
S-001242-12

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Dining Observation

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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.) 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. 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).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan.
Resident's #1087 health care record indicates abnormal blood work. Inspector interviewed staff member S-001 who reported that the plan of care for resident #1087 requires that certain specific foods be avoided as a result of their health history. This was confirmed by the inspector in the review of resident's #1087 health record. Resident #1087 was observed at lunch meal service. Inspector observed that this resident was not provided the diet as outlined in their plan of care. Staff member S-006 confirmed to the inspector that they had made an error with regards to providing the diet as specified in resident's #1087 plan of care.[LTCHA,2007, S.O.2007,c. 8, s. 6 (7)].
2. The licensee has not ensured that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
The plan of care for resident #1087 does not provide clear directions regarding their nutritional needs. The inspector reviewed the home's diet list, physician orders, notes by the Registered Dietitian (RD), and the home's e-plan document. Documentation contained in these sections of the health care record relating to the resident's diet provides conflicting direction. The information contained in the plan of care relating to the resident's diet, does not provide clear directions to staff and others who provide direct care to the resident. [LTCHA,2007, S.O. 2007, c.8,s.6(1)(c)]

Additional Required Actions:

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

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 with s.6(1)(c) to ensure that there is a written plan of care for resident #1087 that sets out 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. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has not ensured that drugs are stored in an area or a medication cart that is secure and locked.
A Critical Incident submitted by the licensee, reports that resident #242 gained access to a drug-related product. Supervisory staff member S-003 confirmed that the area where the drug-related product was kept was not secure or locked. [O. Reg. 79/10, s. 129 (1)(a)(ii)]
2. The licensee has not ensured that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. On Nov.01, 2012 on the second floor, the inspector observed that the box within the medication cart used to store controlled substances had a broken lock. A discussion with supervisory staff members S-002 and S-003 on Nov.01, 2012 confirmed that the lock on the box (within the medication cart) used to store controlled substances was broken and that they were not clear on how long it had been broken. [O. Reg. 79/10, s. 129 (1)(b)].

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion and the information upon which it is based to the Director related to the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
A Critical Incident report submitted by the home indicated that resident abuse had occurred. The home failed to report the incident immediately to the Director as documentation indicates that it was not reported until 16 days after the incident. [LTCHA,2007,S.O.2007,c.8,s.24(1)(2)].

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 that the licensee immediately report the suspicion and the information upon which it is based to the Director related to the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee has not ensured that there are schedules and procedures in place for routine, preventive and remedial maintenance.
A Critical Incident report submitted by the home indicated that a resident gained access to a drug-related product in a cupboard that had a broken lock. Staff member S-007 reported to the inspector on Nov. 01, 2012 that the lock on the cupboard had been "broken awhile". In an interview with supervisory staff member S-003 on Nov. 01, 2012 it was reported that prior to the incident, there was no one checking that locks in the home were functioning properly. On Nov. 01, 2012 inspector interviewed staff member S-004 about routine, preventive and remedial maintenance in the home. Staff member S-004 reported to the inspector that there is no formalized schedule or procedure in place for routine, preventive and remedial maintenance in the home. Supervisory staff member S-003 also confirmed that they are not aware of any schedule or procedures in place regarding routine, preventive and remedial maintenance in the home. [O. Reg. 79/10, s. 90 (1)(b)].

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 there is a schedule or procedure in place for routine, preventive and remedial maintenance in the home, to be implemented voluntarily.

issued on this 20th day of November, 2012

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

Diana Stenlund, #163