Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 28, 2016	2016_269627_0015	002359-14, 001386-15, 003468-16, 008213-16, 018089-16, 019103-16	Critical Incident System

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

SYLVIE BYRNES (627), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 20-24, 2016.

This critical incident inspection is related to the following:
Two critical incidents the home submitted related to alleged staff to resident abuse;
Two critical incidents the home submitted related to resident to resident abuse; and
Two critical incidents the home submitted related to missing money and lottery tickets.

A Follow up inspection, 2016_269627_0016, and a Complaint inspection, 2016_269627_0015, were conducted concurrently.

The Inspector(s) conducted a daily walk through resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staff training records, staffing schedules, policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, family members and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2016_463616_0004	627
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2016_282543_0006	627
O.Reg 79/10 s. 37.	WN	2016_463616_0004	627

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of their investigation and every action taken.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director. The CI identified that an identified resident was missing personal items from their room.

On a specific date, the Director had requested that the CI be amended for further information. The Inspector was unable to locate an amended CI report.

During an interview with the Inspector, the Administrator/Director of Care (Admin/DOC) confirmed that the CI had not been amended to indicate the further required information as requested by the Director. The Admin/DOC was unable to explain why the amendment had not occurred. [s. 23. (2)]

WN #2: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money had occurred or may

occur immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director. The CI identified that an identified resident was missing personal items from their room. The CI indicated that the identified resident had reported the missing personal items to the Administrator/Director of Care (ADM/DOC) on that same day. However, the CI was submitted to the Director one day late.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last revised on June 2016, which identified that staff members were to make an immediate report to the Ministry of Health and Long Term Care (MOH-LTC) Director when there was a reasonable suspicion that misuse or misappropriation of a resident's money occurred.

During an interview on June 21, 2016, with the Inspector, the Admin/DOC confirmed that they had not reported the incident immediately to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director. The CI identified that an identified resident alleged that a PSW had physically harmed them. The CI indicated that the incident occurred on a certain date, however, the CI was submitted to the Director five days later. The CI also revealed that the Charge Nurse interviewed the staff members and the resident at the time of the incident, after a family member who was visiting informed the Charge Nurse of the resident's complaint.

A review of a progress note entered by the Charge Nurse indicated the following:
Two PSWs went to provide care to a specified resident. Family member who was visiting at the time waited out in the hallway. After the care had been provided, the specified resident complained to family member that PSW physically harmed them. Family member approached author who inquired with both PSWs and the specified resident, they were not harmed physically, they were settled with their usual care.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last revised on June 2016, which identified that staff members were to make an

immediate report to the Director where there was a reasonable suspicion that abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred.

During an interview on June 23, 2016, with the Inspector, the ADM/DOC informed the Inspector that the policy at the time of this incident was the same process as it was now; the Charge nurse was to notify the Director immediately of alleged abuse to a resident. The ADM/DOC confirmed that the the Charge Nurse had not reported the incident immediately to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision-maker, if any, was notified of the results of the investigation under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director. The CI identified that an identified resident was missing personal items from their room.

The Inspector reviewed the home's internal investigation file and the documentation on the Mede-care progress notes which revealed that the home had not notified the identified resident or their substitute decision-maker of the results of their investigation.

During an interview on June 21, 2016, with the Inspector, the Admin/DOC reviewed the documentation in their internal investigation file and on the Mede-care computer software and confirmed that the identified resident and their SDM had not been notified of the results of their investigation.

During an interview, the identified resident confirmed that the home had not reported the results of the investigation to them. [s. 97. (2)]

2. Inspector #613 reviewed a Critical Incident Report that was submitted to the Director. The CI identified that an identified resident alleged that a PSW had physically harmed them.

The Inspector reviewed the home's internal investigation file and the documentation on the Mede-care progress notes which revealed that the home had not notified the identified resident or their SDM of the results of their investigation.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last revised on June 2016, which identified that staff were to notify the resident and the resident's SDM, if any, of the results of the investigation immediately and upon the completion of the investigation.

During an interview on June 23, 2016, with the Inspector, the ADM/DOC reviewed the documentation in their internal investigation file and on Mede-care computer software and confirmed that the identified resident and their SDM had not been notified of the results of their investigation. [s. 97. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident, that the licensee suspected may have constituted a criminal offence.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director. The CI identified that an identified resident was missing personal items from their room.

The Inspector reviewed the CI, the home's internal investigation file and the documentation on the Mede-care progress notes which revealed that the home had not notified the appropriate police force of the alleged and suspected abuse.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", revised on June 2016, which identified that staff was to notify the police if they suspected that an alleged, suspected or witnessed incident of abuse of a resident my constitute a criminal offence.

During an interview on June 21, 2016, with the Inspector, the Admin/DOC confirmed that this incident was suspected theft and they should have notified the police. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure they informed the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director to make a report in writing to the Director setting out the immediate actions that had been taken to prevent recurrence.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director by the licensee. The CI identified that an identified resident reported that they were missing specific items from their room. On a specific date, the Director requested the licensee to amend the CI to identify the outcome of the home's full internal investigation.

During an interview on June 23, 2016, with the Inspector, the Admin/DOC confirmed that the CI had not been amended as requested by the Director. [s. 107. (4) 4. ii.]

Issued on this 30th day of September, 2016

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

Original report signed by the inspector.