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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2019	2019_776613_0004	014875-17, 008737-18, 011822-18	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

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): January 8 - 11, 2019.

The following intakes were inspected during this Inspection:

One Critical Incident report that was submitted to the Director regarding a fall resulting in an injury and transfer to the hospital;

One Critical Incident report that was submitted to the Director regarding unknown bruising and injury;

One Critical Incident report that was submitted to the Director regarding resident to resident abuse.

A concurrent Complaint Inspection #2019_776613_0002, Follow up Inspection #2019_776613_0003, and an Other Inspection #2019_776613_0005 were also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Registered Practical Nurses (RPNs), Personal Support Services (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, human resource files and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knew of, or that was reported to the licensee was immediately investigated.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying unknown cause of injuries to resident #008.

A review of the home's policy in place at the time of the incident titled, "Fall Prevention/Management Program, NUM III-27" last revised April 2016, identified that the registered nursing staff would completed an incident investigation and an incident report including all contributing factors.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect, NUM VII-7" last revised January 2019, identified that if investigation and reporting of abuse and neglect was required, staff would immediately investigate reports by staff and residents. The policy further indicated that any action St. Joseph's Manor taken in response to any incident of resident abuse or neglect was to be documented and kept in a secure file.

During an interview with the Administrator/Director of Care (ADM/DOC), they stated when the incident was first reported to them, they had initially suspected abuse may have occurred. The ADM/DOC stated that they had immediately investigated the incident, but did not have further notes or incidents reports to prove that they had. They further stated at the time of the occurrence, that they did not understand the process regarding investigation of suspected abuse. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required a post–fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #613 reviewed a CI report that was submitted to the Director, identifying unknown cause of injuries to resident #008.

A review of the resident's electronic and paper record did not identify that a post falls assessment had been completed.

A review of the home's policy in place at the time of the incident, titled, "Fall Prevention/Management Program NUM III-27" last revised April 2016, identified that when a resident had fallen, the resident would be assessed regarding the nature of the fall and associated consequences the cause of the fall and the post fall care management needs. Complete the falls assessment in software system, complete fall checklist (Appendix B), review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team.

During an interview with RPN #101, they reviewed resident #008's electronic and paper chart and were not able to locate a paper or electronic post falls assessment completed for the resident's suspected fall, and further stated that the ADM/DOC must have it in their office. The RPN provided the Inspector with an incomplete sheet titled, "Checklist and Intervention Resource Guide for Registered Nursing Staff" and stated that this sheet was used as a post falls assessment. RPN #101 stated, they were told by the ADM/DOC that this sheet was changing when the "Fall Prevention/Management Program" policy was revised, but was unaware the policy had been revised, October 2018.

During an interview with the Administrator/Director of Care (ADM/DOC), they stated that post falls assessments were not being completed by staff at that time of this incident. The ADM/DOC confirmed that no post falls assessment had been completed after they had suspected resident #008 had a fall resulting in injury. [s. 49. (2)]

2. Inspector #613 reviewed a CI report that was submitted to the Director, identifying an unknown resident had an un-witnessed fall, which resulted in an injury and transfer to the hospital.

A review of the resident's electronic and closed paper record did not identify that a post falls assessment had been completed.

During an interview with the ADM/DOC, they stated that post falls assessments were not being completed by staff at that time. The ADM/DOC confirmed that no post falls assessment had been completed after resident #007 had a fall resulting in an injury and transfer to the hospital. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident requires a post–fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

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:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of the names of any resident involved in the incident, within 10 days of becoming aware of the incident, or sooner if required by the Director.

Inspector #613 reviewed a CI report that was submitted to the Director, identifying an unknown resident had an un-witnessed fall, which resulted in an injury and transfer to the hospital.

During an interview with the ADM/DOC, they reviewed the CI report and acknowledged that it did not contain the resident's name that was involved in the incident. [s. 107. (4) 2. i.]

2. The licensee has failed to inform the Director of the names of any staff members or other persons who were present at or discovered the incident, within 10 days of becoming aware of the incident, or sooner if required by the Director.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying unknown cause of injuries to resident #008. The CI report did not identify the names of any staff members or other persons who were present at or discovered the incident.

During an interview with the ADM/DOC, they reviewed the CI report and acknowledged that it did not contain the staff member's name that were involved in the incident. [s. 107. (4) 2. ii.]

3. Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying an unknown resident had an un-witnessed fall, which resulted in an injury and transfer to the hospital. The CI report did not identify the names of any staff members or other persons who were present at or discovered the incident.

During an interview with the ADM/DOC, they reviewed the CI report and acknowledged that it did not contain the staff member's name that were involved in the incident. [s. 107. (4) 2. ii.]

4. The licensee has failed to ensure actions were taken in response to the incident, including the outcome of current status of the individual or individuals who were involved in the incident were reported to the Director.

Inspector #613 reviewed a CI report that was submitted to the Director, identifying unknown cause of injuries to resident #008. The CI report revealed that the Director had requested an amendment, and an amendment had not been submitted by the home, to the Director until November 6, 2018.

During an interview with the ADM/DOC, they confirmed that the amendment had been submitted late. They stated that they did not understand the process for mandatory reporting and the time restraints as per the legislation. [s. 107. (4) 3. v.]

Issued on this 18th day of January, 2019

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

Original report signed by the inspector.