Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2019	2019_669642_0016	003990-19, 005552-19, 015822-19	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

AMY GEAUVREAU (642)

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): August 12-16, 2019.

The following intakes were inspected during this Critical Incident System inspection:

- One Log, related to a resident receiving an injury requiring hospitalization which resulted in a significant change,
- One Log, related to resident receiving an injury from an improper transfer.
- One Log, related to an allegation of resident to resident abuse.

A Complaint Inspection, #2019_669642_0015, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Aid, Human Resources Generalist, Personal Support Workers (PSWs), and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 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. 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 any of the following had occurred or may occur, immediately report the suspicion, and the information upon which it was based to the Director: 2. Abuse of a resident by anyone, that resulted in harm or risk of harm.

A critical incident system (CIS) report was submitted to the Director, on an identified date, which alleged physical abuse from resident #004 towards resident #005.

Inspector #642 reviewed the resident's electronic progress notes in Point Click Care (PCC), and the incident had been documented on an identified date. Review of the investigation notes identified resident #005 had identified injuries to a specific area of the body, and medication had been provided.

Inspector #642 interviewed resident #005, who stated that resident #004 had entered an area of the unit, and they had yelled at them to get out, but resident #004 did not leave. Resident #005 described that an altercation ensued resulting in a responsive behaviour of a physical nature towards them, which caused an identified injury.

Inspector #642 interviewed RPN #104, who confirmed that they had witnessed the incident on an identified date, and had reported the information to the Administrator/Director of Care (DOC) at the time of the incident, but did not immediately report it to the Director.

Inspector #642 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect," revised in January 2019, and under actions to be taken by staff; Individual (Administrator/DOC or Charge Nurse) receiving the report, of alleged or actual abuse or neglect, shall call the Ministry of Health Long-Term Care (MOHLTC) immediately, upon establishing reasonable grounds.

In an interview with the Administrator/DOC, they stated that they had received the information for this incident on an identified date, but were off site and did not report the incident immediately to the Director, they stated this incident was reported on an identified date, two days later. [s. 24. (1)]

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 a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, of any abuse of a resident by anyone that resulted in harm or risk of harm, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy, to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented.

A critical incident service (CIS) report was submitted to the Director, on an identified date, which alleged physical abuse from resident #004 towards resident #005.

Please refer to WIN #1 for further details.

Inspector #642 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect," revised on January 2019, and under policy review, annually evaluate the effectiveness of the policy for prevention of abuse and neglect. However, there was no section indicating that the annual review had to be kept as a written record, and it did not describe what was to be included in the review, such as the date of the review, the names of the persons who participated in the evaluation and the date that any changes and improvements were implemented.

In an Interview with the Administrator/DOC, they stated they had not kept a written record of the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, or the specific identified requirements as stated in the Regulations. [s. 99. (e)]

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 a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, includes the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, to be implemented voluntarily.

Issued on this 28th day of August, 2019

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

Original report signed by the inspector.