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

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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
Nov 29, 2019	2019_669642_0024	017871-19	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): November 19-22, 2019.

The following intake was inspected during this Critical Incident System inspection:

- One Critical Incident report, related to an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Ontario (BSO) RPN, Dietary Aid, 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:
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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident, demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. r. 53 (4) (c)

A Critical Incident report was submitted to the Director which alleged physical abuse from resident #001, towards resident #002 on a specific date. Resident #001 had released a safety mechanism from a specific device which resulted in resident #002 experiencing a fall without injury.

Inspector #642 reviewed resident #001's care plan dated on a specific day, that was in effect at the time of this incident. For the Focus, of Mood behavior, the document advised staff to monitor and document the resident's behaviour.

Inspector #642 reviewed the home's investigation file for this incident, and under a document related to monitoring, there were absences of specific monitoring by staff.

The Inspector requested and reviewed a specific amount of months of the documents up to a specific date, when it was implemented. Inspector #642 identified sections of the documents that had staff names assigned, but there were sections on the documentation throughout the specific months, for resident #001's behavioural monitoring that were not documented.

Inspector #642 interviewed Personal Support Worker (PSW) #103, #104, #105 and

#111, Registered Practical Nurse (RPN) #106, #109, and Registered Nurse (RN) #102.They all stated that it was a requirement that the documentation for the Specific Monitoring be fully completed and filled out by staff, and that all sections of the document should be completed. PSW #103 and #111 stated that when they had not completed some sections on the Specific Monitoring document, it may have been a busy day, or they just forgot, or maybe someone was pulled to another unit.

Inspector #642 reviewed the home's policy titled, "Responsive Behaviours Program," Monitoring and Communication section, last revised on April 2019, which directed staff to observe and document the resident's response to the care plan strategies.

Inspector #642 interviewed Behavioural Support Ontario (BSO) RPN #108, who stated staff were not completing another [specific behavioural document] fully, because the staff did not fully understand them. BSO RPN #108 stated they then created the Specific Monitoring intervention document, and stated it was a requirement that the document be completed fully, with documentation of the resident's behaviours.

The Inspector interviewed the Administrator/Director of Care (DOC), who stated the Specific Monitoring document was supposed to be fully completed and filled out, and the staff were supposed to follow the procedure. After Inspector #642 and the Administrator/DOC reviewed the specific months of the Specific Monitoring sheets for resident #001, there was identified missing documentation. [s. 53. (4) (c)]

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 for each resident, demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A Critical Incident report was submitted to the Director which alleged physical abuse from resident #001, towards resident #002 on a specific date.

The Inspector reviewed resident #001's progress notes and identified under, "Behaviour Notes," that the staff had been completing, a specific monitoring regime with resident #001, due to the resident's responsive behaviours.

Inspector #642 reviewed the home's investigation file, and a document titled, "[A Specific] Monitoring," and identified there were no staff signatures written after a specific time on a specific date, and there was a note at the bottom of the document stating, "received at [a certain time], zero sign off for [a specific amount of] hours."

The Inspector reviewed the investigation file, and there was another document with a time line written out, of the incident. The Administrator/DOC stated later, that they had reviewed the surveillance video for a specific date, and this was the time line they had created. The time line identified that from a certain time to a certain time, there were no staff members monitoring resident #001 while they were in a specific area.

The Inspector interviewed PSW #100, #103, RPN #101, and RN #102, who stated

resident #001 was on a specific intervention and it was part of their plan of care. The staff watching resident #001 were instructed to monitor resident #001 at all times, due to their specific responsive behaviours, then they were to sign and check off the time spent with the resident, and document the resident's behaviour's on this Specific Monitoring document.

Inspector #642 interviewed PSW #111 and PSW #112, who had been working a specific day, the day of the incident, and they identified there had been some confusion over who had been watching resident #001 at the time of the incident. PSW #111, stated they had left the dining room with another PSW, and had assumed the staff in the dining room would be monitoring resident #001. PSW #112, stated they were taking turns watching resident #001, and since they had not written their names down on the Specific Monitoring sheet, it was unclear who was supposed to be monitoring resident #001 at the time of the incident. PSW #112 stated they had left the dining room with PSW #113, and had not witnessed the incident.

The Inspector interviewed Dietary Aid #107, who had been working on that specific day. They stated they came out of the servery area when they heard resident #004 calling, and then witnessed resident #002 on the floor. They had to go get help, because there were no staff members in the dining room.

The Inspector reviewed the home's policy titled, "Responsive Behaviours Program," last revised April 2019, it stated under, "Develop strategies for prevention," developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situations.

Inspector #642 interviewed the BSO RPN #108. They stated the "[Specific] Monitoring," was implemented as part of the resident's daily plan of care on a specific day and had been in place since then. The BSO RPN #108 stated staff were required to monitor resident #001 and complete the documentation on the, "[Specific] Monitoring" intervention tool they had implemented.

The Inspector interviewed the Administrator/DOC, who had investigated this incident and had reviewed the home's video footage and interviewed the staff. The Administrator/DOC stated the four PSW's that day had decided to go by, "word of mouth," as to who should be monitoring resident #001, instead of writing down the staff names on the Specific Monitoring document. It became unclear who was supposed to be monitoring resident #001; to the point that, no staff were providing the Specific Monitoring when the incident

happened at a specific time. The Administrator/DOC stated staff had not been providing the "[Specific] Monitoring," as required and outlined, and they were not implementing the intervention for resident #001 at the time of this incident. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

Issued on this 3rd day of December, 2019

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

Original report signed by the inspector.