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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 3, 5, 2011	2011_057163_0008	Mandatory Reporting

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 Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC),registered nursing staff, personal support workers (PSWs), Administrative Assistant and residents.

During the course of the inspection, the inspector(s) reviewed the homes Mandatory Reporting documentation.

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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 sayants :

1. The licensee failed to notify the Director of the results of the investigation of a Mandatory Report incident. The inspector interviewed the Admin Assistant on Aug 03/11 who indicated that the results of the investigation regarding the Mandatory Report were not reported. The inspector interviewed the Administrator/DOC who reported "if the notes in the documentation did not indicate that I called/contacted the Ministry with the results of the investigation then I guess that I did not ".
2. The inspector reviewed the licensee's mandatory investigation notes from March 23/11. It was documented that after receiving the results of the police investigation, the words "Ministry to be notified" were written, however the licensee failed to report the results of the mandatory report investigation to the Director.

WN #2: 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 sayants :

1. Police were not immediately notified by the licensee of the alleged abuse incident. The inspector interviewed the Administrator/DOC on Aug 3/11 who stated "I did not immediately inform the police until I spoke with the Duty Inspector on March 21/11 and she informed me that I needed to contact the police".
2. The inspector reviewed a Mandatory Report from the Critical Incident System. Date of incident was recorded as March 08/11. The home's documentation notes of the incident indicates that police were not contacted until March 21/11.

Issued on this 7th day of September, 2011

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

Diana Stenlund