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
Nov 21, 22, 24, Dec 14, 2011	2011_099188_0031	Critical Incident

Licensee/Titulaire de permis

Sault Area Hospital
969 Queen St. East, SAULT STE. MARIE, ON, P6A-2C4

Long-Term Care Home/Foyer de soins de longue durée

GREAT NORTHERN NURSING CENTRE LIMITED
860 Great Northern Road, Sault Ste Marie, ON, P6A-5K7

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing staff, Personal Support Workers, activation staff, housekeeping staff and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident care areas, observed resident-staff interactions, reviewed health care records and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Inspector reviewed the plan of care for an identified resident on November 21, 2011. Inspector noted that the care plan under a section related to responsive behaviours identifies a specific intervention. Inspector observed on November 21 and 22, 2011 that this intervention was not followed. Inspector spoke with a Registered Nurse (RN) who identified the resident continues to refuse the intervention and that it is not currently being followed. The licensee failed to ensure the resident is reassessed and the plan of care reviewed when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Resident Abuse". This policy does not include an explanation of the duty under section 24 of the Act to make mandatory reports. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents includes an explanation of the duty under section 24 of the Act to make mandatory reports. [LTCHA 2007, S.O. 2007, c.8, s.20(2)(d)]

WN #3: 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 subsections:

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

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. An incident of resident to resident abuse was reported to the Director 64 days after it occurred. This is outside of the immediate reporting time frame. The licensee failed to ensure that abuse of a resident by anyone was immediately reported to the Director. [LTCHA 2007, S.O. c.8, s.24(1)(2)]
2. Inspector reviewed a critical incident report. This incident of resident to resident abuse was reported to the Director 58 days after it occurred. This is outside of the immediate reporting time frame. The licensee failed to ensure that abuse of a resident by anyone was immediately reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]

Issued on this 29th day of December, 2011

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