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 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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 2, 2016 | 2016_320612_0015 | 002703-15 | Critical Incident System |

### Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

SARAH CHARETTE (612)

## 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): June 15- 17, 2016.**

**This inspection is related to Critical Incidents (CI) submitted to the Director by the home, four related to staff to resident abuse and two related to missing/unaccounted for controlled substance.**

**A Complaint Inspection #2016_320612_0016 was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Service Manager (FSM), residents and their family members.**

**The Inspector conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, and policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy that promoted zero

tolerance of abuse and neglect of residents was complied with.

The Inspector reviewed a Critical Incident (CI) report which alleged verbal abuse of resident #001 by an unknown PSW. Resident #001 stated that the PSW spoke very loudly and abruptly to them and the PSW refused to provide their name when the resident asked for it. Resident #001 was unable to visualize the PSW. The resident reported the incident to RN #108 on a specific date in January 2015 and the RN charted a progress note, however the CI was no completed until a specific date in February 2015.

The Inspector reviewed the investigation notes provided by the home. The DOC interviewed all staff members working around the time of the incident and they were unable to establish who the staff member was, although in the CI report they specifically mentioned PSW #103. The home was unable to substantiate the abuse.

The Inspector reviewed the home's policy titled, "Zero Tolerance for Abuse and Neglect," last reviewed September 14, 2015, which stated that staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone and neglect of a resident by a staff member of the home.

The Inspector interviewed the DOC who stated that RN #108 had not followed the home's policy, they did not report the incident immediately to the home, and therefore the CI was filed late. The DOC stated that as soon as they were aware of the incident, they notified the Director. [s. 20. (1)]

2. Inspector #612 reviewed a CI report which alleged that PSW #103 made a statement towards resident #004's and used profane language so that the resident could hear. The incident occurred and was reported to the ADOC on a specific day in May 2016, however the CI report was not reported to the Director until six days later.

The Inspector reviewed the home's investigation notes and the abuse was substantiated. The PSW #103 was disciplined.

During an interview with PSW #103 they confirmed that they had made the statement but denied using profane language. They confirmed that they had received discipline from the home.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance for Abuse and

Neglect," last reviewed September 14, 2015, which stated that the organization was committed to their core values of Dignity, Excellence, Service and Integrity and to promoting a zero tolerance of abuse or neglect of its residents. 'Zero tolerance' within their policy meant, that the facility shall uphold the right of the residents within the facility to be treated with dignity and respect and to live free from abuse and neglect.

The Inspector interviewed the ADOC who stated that through their investigation they were able to substantiate that PSW #103 had made the statement towards resident #004 and used profane language; therefore PSW #103 was disciplined. The ADOC stated that there was zero tolerance for abuse in the home. [s. 20. (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 the home's policy titled, "Zero Tolerance for Abuse and Neglect," last reviewed September 14, 2015, is complied with, to be implemented voluntarily.***

---

**WN #2: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #612 reviewed a CI report which alleged that PSW #103 had made a statement towards resident #004's and used profane language so that the resident could hear. The incident occurred and was reported to the ADOC on a specific day in May 2016, however the CI report was not reported to the Director until six days later.

The Inspector reviewed the home's investigation notes and the abuse was substantiated. The PSW #103 was disciplined.

During an interview with PSW #103 they confirmed that they had made the statement but denied using profane language. They confirmed that they had received discipline from the home.

The Inspector interviewed the ADOC who stated that the incident was reported to them on the specific day in May 2016, and they did not complete the CI report until six days later. They were unable to provide an explanation why. [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 the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director, 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**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:**

**4. Analysis and follow-up action, including,**
**i. the immediate actions that have been taken to prevent recurrence, and**
**ii. the long-term actions planned to correct the situation and prevent recurrence.**
**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident.

a) The Inspector reviewed a CI report which reported that a controlled substance was missing or unaccounted for. The CI stated that the incident occurred on specific date in December 2015, and it was reported the same day.

The Inspector reviewed the investigation notes provided by the ADOC. The notes stated that the RPN # 105 was placed on a leave of absence eight days prior to when the CI was filed, while the home conducted an investigation into their documentation practices related to controlled substances.

The Inspector interviewed the ADOC who stated that they were unsure if they had to notify the Director related to this incident and confirmed that they had filed it late.

b) The Inspector reviewed a CI report which reported that a specific quantity of a specific controlled substance was unaccounted for. The CI was dated a specific date in January 2016 and the information was submitted to the Director on a specific date in May 2016.

The Inspector reviewed the investigation notes provided by the ADOC and noted that the Pharmacist Consultant had first reported the unaccounted ampules of hydromorphone in December of 2015.

The Inspector interviewed the ADOC who stated that they were unaware they were required to report the unaccounted controlled substance to the Director. The Administrator stated in an interview that as soon as they had been made aware of the missing controlled substance they provided the direction to report the incident to the Director. They confirmed that they were late in notifying the Director. [s. 107. (3) 3.]

2. The licensee has failed to ensure that the long-term actions planned to correct the situation and prevent recurrence were included in the report to the Director.

The Inspector reviewed a CI report which stated that a controlled substance was missing/unaccounted for. Under the heading "What long-term actions are planned to correct this situation and prevent recurrence" the home had listed "pending further investigation".

The Inspector reviewed the investigation notes provided by the home which included a copy of the CI that the home had submitted. No change was made to the report to indicate the long-term actions.

The Inspector interviewed the ADOC who confirmed that the CI had not been updated to include the long-term actions. [s. 107. (4) 4. ii.]

***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 the Director be informed of all missing or unaccounted for controlled substances no later than one business day after the occurrence of the incident, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following:**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written Medication management system policies and protocols were implemented.

Inspector #612 reviewed two CI reports submitted to the Director related to missing/unaccounted for controlled substances. One reported that the home suspected RPN #105 was taking a resident’s controlled medication and another reported that a specific quantity of a specific controlled substance was unaccounted for.

The Inspector observed a shift change monitored drug count on a specific date in June 2016. RPN #119 arrived for a specific shift and went into the medication room while RPN #118, from the previous shift remained outside the room. RPN #119 completed the monitored drug count on their own. On another date in June 2016, the Inspector observed RPN #117 arrive for their shift on the unit and go into the medication room and completed the monitored drug count on their own.

During an interview with RPN #117 and #118, they stated that two registered staff were supposed to complete the monitored drug count together, however they usually completed the count before the next shift arrived and the oncoming registered staff member would complete the count on their own.

The Inspector reviewed the home's policy titled, "Shift Change Monitored Drug Count," policy number 6-6, which stated that two registered staff (leaving and arriving), together count the actual quantity of medication remaining, record the date, time, quantity of medication and sign in the appropriate spaces on the "Shift Change Monitored Medication Count" form and confirm the actual quantity was the same as the amount recorded on the "individual monitored medication record".

The Inspector interviewed the ADOC and the Administrator who confirmed that it was the expectation that the monitored medication count be completed with two registered staff, "together". [s. 114. (3) (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 the home's policy titled, "Shift Change Monitored Drug Count," policy number 6-6, is implemented by registered staff, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**4. Analysis and follow-up action, including,**
**i. the immediate actions that have been taken to prevent recurrence, and**
**ii. the long-term actions planned to correct the situation and prevent recurrence.**
**O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

Inspector #612 reviewed a CI report which alleged that PSW #103 had made a specific statement and used profane language so that the resident could hear. Under the heading "what long-term actions are planned to correct this situation and prevent recurrence" it stated "long term actions could be that we move the PSW to another unit".

The Inspector interviewed PSW #103 who stated that they had not been moved units, however they no longer provided care to resident #004.

The Inspector interviewed the ADOC who stated that the staff member received specific discipline following the incident. The ADOC confirmed this information was not included in the report to the Director. [s. 104. (1) 4.]

---

**Issued on this 2nd day of September, 2016**

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

**Original report signed by the inspector.**