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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 24-25, 2011	2011_158_2913_24Jan160815	Other-critical incident MIS 2913-000016-10 S-00737

Licensee/Titulaire
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

Name of Inspector/Nom de l'inspecteur
Kelly-Jean Schienbein # 158

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Director of Care (DOC), 4 Registered nursing staff, 1 physician, 2 personal support workers (PSW), housekeeping staff

During the course of the inspection, the inspector: conducted a walk through of homes areas and various common areas, observed residents, observed staff practices and interactions with the residents, reviewed the health records of residents and reviewed the home's policy CM-U-010- unusual occurrence reports , CM-H-105- head injury, CM-F-009- falls prevention

The following Inspection Protocols were used during this inspection:
Critical Incident
Falls Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

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

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, c. 8, s. 6 (1)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

- The care plan of a resident who fell was reviewed by the inspector on January 25/11. The resident's care plan did include interventions regarding fall prevention however it did not identify the physician's direction to monitor the resident for increased inter-cranial pressure symptoms. The written plan of care did not set out clear directions to staff or others providing direct care to the resident.

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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 all residents at risk to fall have written plans of care which set out clear direction, to be implemented voluntarily.

WN # 2: The Licensee has failed to comply with LTCHA 2007, c. 8, s. 6 (10) (b).
The licensee shall ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary;

Findings:

- The health record of a resident was reviewed by the inspector on January 25/11. The resident's health record identified that the resident had a previous fall that resulted in a transfer to hospital for a Head Injury. The resident's care plan did not reflect this health status change, nor set out additional neurological monitoring as directed by the physician upon the resident's return from hospital. The care plan was not revised when the resident's needs changed.

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care are revised when the resident's care needs change, to be implemented voluntarily.

WN # 3: The Licensee has failed to comply with O Reg 79/10, s. 49(2)
Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

- The care plan of a resident was reviewed by the inspector on January 25/11. The resident had an unwitnessed fall. The resident's initial assessment by the RPN included vital signs however there was no documentation to indicate that an inter-cranial assessment had been done. No further assessment of the resident post fall was found to be documented until the resident's condition changed significantly that same day and the RN was notified.
- The RN and DOC confirmed during interviews on January 25/11 with the inspector that a post-fall assessment on the resident was not conducted by the RPN.
- The strategies to assess a resident post fall found in the home's head injury policy CM-F-009 was reviewed on January 25/11 by the inspector. The policy includes assessments of pulse, respiration, blood pressure, and level of consciousness to be monitored at: the time of injury, every 30 minutes for the first two hours, every hour for four hours and every shift for 48 hours. The health records of three residents who had recent falls were reviewed. The records show that the home's head injury assessments were not consistently completed as per the above policy.
- The licensee did not ensure that a post fall assessment was conducted.

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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 in ensuring that a post fall assessment is completed on all residents who require it, to be implemented voluntarily.

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WN # 4: The Licensee has failed to comply with LTCHA 2007, c.8, s. s24(1)4
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: Misuse or misappropriation of a resident's money.

Findings:

- A Mandatory report of alleged misuse/misappropriation of resident's money was reported however, the alleged incident occurred six days earlier. The home did not immediately report the incident to the director.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).
	Schuerber July 29/11