Ontario

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
Direction de l'amélioration de la performance et de la conformité

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Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
May 26-27, 2011	2011_188_2913_26May132000	Complaint S-001228-11, IL-17904-SU S-001253-11, IL-18016-SU S-001258-11, IL-18067-SU

Licensee/Titulaire
St. Joseph's Health Centre of Sudbury, 1140 South Bay Road, Sudbury, ON, P3E 0B6, Fax: 705-673-1009

Long-Term Care Home/Foyer de soins de longue durée
St. Joseph's Villa - Sudbury, 1250 South Bay Road, Sudbury, ON, P3E 6L9, Fax: 705-674-9550

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm (188)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: Director of Care (DOC), Registered Nursing Staff, Personal Support Workers, Activation Staff and Residents

During the course of the inspection, the inspector: conducted a walk through of resident care areas, reviewed complaint response and nursing department schedules.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing
Reporting and Complaints

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

2 WN

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, S.O. 2007, c.8, s.8(3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Findings:

1. Inspector reviewed the home's registered nurse (RN) schedules dated February 1st, 2011 until May 8, 2011. Inspector noted that an RN was not in the home for the night shift on April 27, 2011. This was confirmed by the DOC who indicated an RN was available via telephone. The licensee failed to ensure there was at least one RN who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Inspector ID #:	188

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.17(1)(a) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

Findings:

1. Inspector was approached by a resident in the hallway. This resident indicated to the inspector that they were looking for staff. The resident informed the inspector that the wireless call badge was not working and assistance was required. Inspector proceeded to press the residents wireless call badge, confirming it did not activate. Inspector asked the resident if a cord was available in the resident's room. The resident indicated that the home was currently switching to cords but one is not yet in the residents room. Inspector proceeded to find a staff member to assist the resident. Inspector spoke with the DOC who confirmed that the old wireless call badge system should be functional until the new system is completely installed. The licensee failed to have a communication and response system which is accessible and on at all times.

Inspector ID #:	188

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). June 9, 2011