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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2018	2018_671684_0016	010175-18, 010178-18, 010180-18	Follow up

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

SHELLEY MURPHY (684), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 3-6, 2018.

The following intakes were inspected upon during this Follow Up Inspection:

Compliance Order (CO) #001 from Inspection report #2018-638609-0005, related to s.6 (7) of the Long-Term Care Home Act (LTCHA), 2007, specific to ensuring that the care set out in the plan of care is provided to the resident as specified in the plan;

CO #002, regarding s.26 (3) of the LTCHA, 2007, specific to ensuring a interdisciplinary assessment of a resident's mood and behaviour pattern including responsive behaviours and triggers are outlined in the resident plan of care; and,

CO #003, regarding s.8 (1) (a) (b) of the LTCHA, 2007, specific to ensuring there is an organized program of nursing services for the home to meet the assessed needs of the residents and an organized program of personal support service for the home to meet the assessed needs of the residents.

A Complaint Inspection #2018-671684-0015, and a Critical Incident Inspection #2018 -671684-0014, were conducted concurrently with this Follow up Inspection.

The inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, and internal investigation files, human resource files and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager, Registered Practical Nurses (RPNs), Personal Care Attendants (PCAs), residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #002	2018_638609_0005	684
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_638609_0005	684
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #003	2018_638609_0005	684

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #684 observed resident #019 sitting in a resident area for a two hour period of time. At the two hour mark, resident #019 was offered their medications by RPN #107.

Inspector #681 reviewed resident #019's medication administration record, which indicated that they were to be administered a number medications at the start of the two hour time frame. The Inspector also reviewed the Physician's Orders Audit Report, which indicated that RPN #107 documented that they had attempted to administer resident #019's medications at the end of the two hour time frame.

During an interview with RPN #107, they indicated that, on average, the medication pass on their resident area ends around the two hour mark after the perscribed medication administration time. RPN #107 stated that the medication pass did not finish until approximately two and a half hours after the perscribed administration time, and that resident #002 was the last resident to receive their medications on this day, due to a choice resident #002 made. However, RPN #107 stated that they did not delay or prolong the medication pass because of the choice resident #002 made, they administered medications to all other residents on the unit and waited until the end of the medication pass to administer resident #002 their prescribed medications.

Inspector #681 noted that the unit where resident #019 resided was fully staffed.

During an interview with RPN #111, they indicated that, on average the medication pass on the resident home area where they work ends approximately two hours after the perscribed medication administration time. RPN #111 stated that best practice was for residents to be administered their medications between one hour before and one hour after the time specified by the prescriber.

Inspector #681 reviewed the home's policy titled "The Medication Pass" (Policy 3-6), which indicated that the right resident receives the right medication of the right dose, at the right time, by the right route for the right reason and completed the right documentation.

During an interview with the DOC, they stated that the home's policies did not include guidelines about when medications were to be administered to residents relative to the time that had been specified by the prescriber. However, the DOC stated that best practice was for medications be administered between one hour before and one hour after the time specified by the prescriber. The DOC acknowledged that medications were

not always being administered to residents between the best practice two hour time frame and they stated that they expected nursing staff to use their clinical judgement as to whether to administer or hold the next dose based on the time that the previous medications were administered. The DOC stated that they did not believe there was any risk to the residents of the home associated with the delayed medication administration pass. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 12th day of July, 2018

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

Original report signed by the inspector.