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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2019	2018_752627_0027	004907-18, 019386-18, 023867-18, 024713-18, 025022-18, 028318-18, 028331-18, 028347-18, 029622-18, 030176-18	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

SYLVIE BYRNES (627), SHELLEY MURPHY (684)

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): December 6-7, 11-13 and 17-21, 2018.

A Complaint inspection, #2018_752627_0026, was completed concurrently with this Critical Incident System inspection. NOTE: written notification related to Long Term Care Homes Act (LTCHA), 2007, s 6 (7) identified in the Inspection, has been issued in the Complaint Inspection Report #2018_752627_0026.

The following intakes were completed in this Critical Incident System inspection:

- Two logs related to falls;
- Six logs related to resident to resident abuse;
- One log related to an outbreak; and,
- One log related to missing narcotics.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Executive Assistant of the Board of Liaison, Admission Coordinator, Behavioural Supports Ontario, Registered Practical Nurse (BSO RPN), Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation notes, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Recreation and Social Activities
Responsive Behaviours

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)**

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	Légende 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A critical incident system (CIS) report was submitted to the Director regarding an infectious disease outbreak.

Inspector #627 reviewed the home's policy titled "Surveillance for Infection Control", issued August 25, 2010, which indicated that RNs/RPNs were to document in progress notes every shift relating to the presence or absence of signs and symptoms. Documentation was to continue until symptoms subsided or 48 hours after antibiotics were completed.

Inspector #627 reviewed the home's investigation notes and noted that residents #007, #019 and #021 had been under isolation precautions during the outbreak. Inspector #627 reviewed the residents' progress notes and vitals in Point Click Care (PCC) and noted the following:

Resident #007 was under isolation precautions for a period of six days. The Inspector could not identify any assessments of the resident's symptoms for a specified date, for two different shifts.

Resident #019 was on isolation precautions for a period of three days. The Inspector was unable to identify an assessment of the resident's symptoms for two specified dates, for a particular shift.

Resident #021 was under isolation precautions for a period of four days. The Inspector was unable to identify an assessment of the resident's symptoms for two specified dates, for a particular shift.

Inspector #627 conducted separate interviews with Registered Practical Nurse (RPN) #113 and Registered Nurse (RN) #105. Both stated that during an outbreak, residents exhibiting symptoms of infection were to be assessed on every shift, and the assessment should have been documented in PCC.

Inspector #627 interviewed the Assistant Director of Care (ADOC) who stated that during an outbreak, all residents exhibiting symptoms should be assessed on every shift, and the assessment was to be documented in PCC. Upon a review of resident #007, #019 and #021 electronic chart in PCC, they confirmed that there was no documentation to indicate that the residents had been assessed on the aforementioned dates. [s. 229. (5) (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 on every shift, symptoms indicating the presence of infection in residents, were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 11th day of January, 2019

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

Original report signed by the inspector.