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_0026	016945-18, 020352-18, 026580-18, 029960-18	Complaint

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 6-7, 11-13 and 17-21, 2018.

A Critical Incident System (CIS) inspection, #2018_752627_0027, was completed concurrently with this Complaint inspection. NOTE: written notification related to Long Term Care Homes Act (LTCHA), 2007, s. 6 (7) identified in CIS Inspection, #2018_752627_0027, will be issued in this report.

The following intakes were completed in this Complaint inspection:

- One log related to alleged abuse and pain management;
- One log related to staffing;
- One log related to an admission refusal; and,
- One log related to alleged neglect of a resident.

Inspector Shelley Murphy (#684) attended this inspection, along with Inspector #627.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Admission Coordinator, Executive Assistant of the Board of Liaison, Registered Nurses (RNs), Registered Practical Nurses (RPNs), 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 records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

6 WN(s)
4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director in regards to insufficient staffing in the home. The complainant stated that the home was often short staffed, and that care was not provided to the residents as it should be. The complainant stated that they had been told by an RPN (unsure of name) that during the summer months (unsure of date), resident #008 was discovered in need of care that had not been provided during the previous shift.

A.

During an interview, PSW #104 shared an email with Inspector #627, that they had submitted to RPN #114, on a specific date, regarding concerns with the care of the residents on a specific unit of the home. The letter indicated that on a specific date and time, PSW #104 had found that residents #005, #021, #023, #024, #025, #026, #019, #015, #027 had not been provided with care. Residents #001, #003, #020 #013, #018 and #022 also needed to be provided with care. Resident #026 was found to not have been provided with care, as well. The email indicated that the PSW was concerned about how long the residents were left without care. The email alleged that this compromised their skin integrity, as well as pushed the following shift's routine back, which resulted in being late to the dining room. The email indicated that the specific shift had been short staffed.

Inspector #627 reviewed the home's policy titled "Care Planning", last revised November 28, 2018, which indicated that the interprofessional team members were to provide care to the resident as set out in the plan.

Inspector #627 reviewed the progress notes for the above mentioned residents and identified documentation from PSW #119, dated two days after the above specified date, which indicated that they had been unable to complete care for residents #003, #017 and #018, as there was no float PSWs and that registered staff had been made aware.

Inspector #627 reviewed the residents' care plans in effect at the time of the incident and noted that resident #003, #017 and #018 were to be provided with specific care, at specific times during the shift.

Inspector #627 interviewed PSW #119. They stated that they recalled working and documenting about the care that they were unable to complete. They stated that the shift had been especially chaotic and they had reported to the RN the care they had been unable to complete.

Inspector #627 interviewed PSW #121 who stated that they had worked on the specified date. PSW #121 stated that they had been short staffed on that particular shift; PSW #121 stated that they had no help from another staff member, therefore; the care had not been provided to the residents.

Inspector #627 interviewed RPN #114 who stated that the incident was reported to them and they had asked PSW #104 to document the findings in an email which they had forwarded to the Director of Care (DOC) and Assistant Director of Care (ADOC).

Inspector #627 interviewed RPN #113 who stated that the home tended to be short staffed very often. RPN #113 stated that they often heard from the PSWs, that many residents had not seemed to be provided with care, at a specific time. They further stated that staffing was an ongoing issue.

B.

During an interview with Inspector #627, PSW #121 stated that they had worked one PSW short on a specific recent date, and that a staff member left for the remainder of the shift. PSW #121 stated that they had been re-assigned to a specific unit, after having been the float PSW for the entire home. The PSW stated that they had went to another unit of the home, at a specific time, to assist with the residents needing assistance from two staff members. They had returned to their assigned unit at a later time, and had not had the time to provide care to residents #029, #030, #031, #032 and #033. PSW #121 stated that when they were short staffed and unable to complete care, they notified the

RN; however, they never had the time to chart in the resident's charts about the care that had not been provided.

Inspector #627 reviewed the care plans for the aforementioned residents and noted that resident #029, #030, #031, #032 and #033 were to be provided with specific care at a specific time.

Inspector #627 interviewed the DOC who acknowledged that the aforementioned residents had not been provided care as indicated in their care plan. The DOC further stated that they had begun requesting audits of resident care for every shift. [s. 6. (7)]

2. Inspector #684 reviewed a critical incident system (CIS) report submitted to the Director, related to resident to resident abuse between resident #004 and resident #005.

During a review of resident #004's care plan, which was in place at the time of the incident, Inspector #684 noted a specific intervention in regards to the resident's medications, especially when the resident refused their medications.

Inspector #684 reviewed resident #004's electronic medication administration record (eMAR) which showed that a specific medication was to be administered daily. The specific intervention had not been applied when resident #004 refused this medication.

Inspector #684 reviewed the home's policy titled "Care Planning", last revised November 28, 2018, which stated the following under objective: "The care plan serves to: Communicate significant information about the resident/patient to the interprofessional team; Document necessary actions for providing quality care for the resident/patient; Communicate the resident/patient's needs and diagnoses, and any contributing factors; Promote continuity of care; and evaluate the resident/patient's progress and determine if expected outcomes have been achieved."

During an interview with Inspector #684, RPN #126 confirmed that the specific intervention had not been applied when resident #004 had refused their medication.

Inspector #684 interviewed RN #125 regarding how the specific intervention would have been carried out. RN #125 explained to Inspector #684 how the specific intervention would be carried out.

During an interview with Inspector #684, the DOC stated that staff were to follow a

resident's care plan. The DOC stated the specific intervention should have been carried out when resident #004 had declined their medication. [s. 6. (7)]

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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home that met the assessed needs of the residents.

A complaint was submitted to the Director in regards to insufficient staffing, in the home. The complainant stated that the home was often short staffed and that care was not provided to the residents as it should be. Please see WN #1, finding 1, A and B, for details.

Inspector #627 reviewed the home's policy titled "Staffing Plan", dated August 8, 2014, which identified the personal support staffing compliment and a staff replacement process when staff were unable to attend to their shift.

Inspector #627 reviewed the staffing complement for a specified date and specific shift and identified that one PSW had been assigned to a specific unit for a five hour period.

No other staff had been available to complete the remainder of the shift It was also noted that no PSW had been assigned to the unit for the shift on the following day.

Inspector #627 interviewed PSW #119. They stated that they recalled working two days after the alleged incident, and documenting about the care that they were unable to complete. They stated that the shift had been especially chaotic. PSW #119 further stated that they had reported to the RN the care they had been unable to complete and they had completed documentation to indicate what had not been completed.

Inspector #627 interviewed PSW #121 who stated that they had worked during the shift of the alleged incident. PSW #121 stated that they had been one PSW short staffed on that particular shift; therefore, a float PSW had been assigned to a unit and they (PSW #121) had been the float PSW for the home (four units). At a specific time, they were re-assigned to another unit. PSW #121 stated that they had no help for anyone who required the assistance of two staff member, as no one was available; therefore, the care had not been provided to the residents.

Inspector #627 interviewed PSW #109 who stated that for the last two years, the usually worked on a specific unit. PSW #109 stated that the full complement of staff comprised of one PSW per unit, with one PSW who floated between the two units on the floor; however, they often worked short staffed. PSW #109 explained that when the home was short staffed, the float PSW was assigned to a unit and the RPN was to assist with resident care; however, the RPN and RN often told the PSWs that they were too busy to assist with resident care. PSW #109 stated that the residents needing two staff members for care had not received the care they required and that they reported what resident had not received care to the next shift.

Inspector #627 interviewed RPN #114 who stated that they had brought forth to management that when the home was short staffed, care was not provided to the residents as was indicated in their care plan.

Inspector #627 interviewed RPN #113 who stated that the home tended to be short staffed very often. RPN #113 stated that they often heard from the PSWs, discussing how many residents had not been provided with care. They further stated that staffing was an ongoing issue.

Inspector #627 interviewed the DOC who acknowledged that residents were not provided with care as indicated on their care plan, at times, when the home was short of staff. The

DOC stated that when this occurred, they expected the following shift to provide those residents who had not received their planned care, with care first. [s. 8. (1) (b)]

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 has an organized program of personal support services for the home to meet the assessed nees of the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A complaint was submitted to the Director in regards to insufficient staffing. The complainant stated that the home was often short staffed on a specific shift, and that care was not provided to the residents as it should be. Please see WN #1, findings A and B, as well as WN #2 for details.

Ontario Regulation (O.Reg.) 79/10, of the Long-Term Care Home Act (LTCHA),2007, defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Inspector #627 reviewed the home's policy titled "Zero Tolerance for Abuse and Neglect", last revised July 6, 2018, which defined neglect as "the failure to provide a

resident with the treatment, care, services or assistance required for health, safety or well-being, dignity or self-worth and includes inaction or a pattern or inaction that jeopardizes the health, safety or well-being of one or more residents".

Inspector #627 interviewed the ADOC who stated that they defined neglect as a resident not receiving the care they required. The ADOC stated that staff were advised to report any allegations of neglect immediately to the RN or management verbally; not by email. The ADOC stated that when they received an email alleging abuse or neglect, the DOC along with them, began an investigation and reported the alleged incident to the Director immediately. The ADOC stated that they had not discussed the two emails with any of the staff; however, they had been involved in developing the care audits. They further stated that the emails were sent to the DOC and they would have been the one to investigate and report the incidence of neglect if it was substantiated.

Inspector #627 interviewed the DOC who defined neglect as a PSW purposely and improperly treating a resident; not providing a meal, removing their call bell or not meeting the resident's needs. The DOC stated that when they had received the two emails, they had mistakenly assumed that the emails pertained to the same incident documented in one of the email. For this reason, the other email's allegations, had not been investigated or reported to the Director. The DOC stated that they had called PSW #119, in regards to the later email, as they had been the PSW on duty in the specific unit. The DOC stated that PSW #119 had been remorseful of not being able to complete all of the resident's care; they were simply too busy to provide all the care the residents required. The DOC further stated that they had not felt this constituted neglect as it was not intentional, and that no further investigation had taken place, nor was the alleged incident reported to the Director. The DOC stated that they had not felt that the absence of care was neglect, if the residents were seen during at all during the shift; the DOC stated that had a PSW said that they had not seen a resident at all, that would had constituted neglect". They stated that they had felt the emails were part of a conflict between PSWs; on each shift, they had blamed each other for work that was not completed. The DOC further stated that they had implemented a shift audit of resident care as it was evident that PSWs were feeling that other PSWs were reporting them.

The licensee was also cited for failure to comply with the LTCHA, 2007:

- s.23, that the Licensee must investigate, respond and act. Please refer to WN #4 for additional details;

- s.20 (1), the policy to promote zero tolerance of abuse was complied with. Please refer to WN #5 for additional details, and;

- s.24, reporting certain matters to the Director. Please refer to WN #6 for additional details. [s. 19. (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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the staff was investigated immediately.

During an interview, PSW #104 shared an email with Inspector #627 alleging neglect of multiple residents. Please see WN #1, finding 1, A and B, for details. PSW #104 stated that they had been asked by RPN #115 to document their concerns in an email and forward it to them, which they had done.

Inspector #627 reviewed the home's policy titled "Zero Tolerance for Abuse and Neglect", last revised July 6, 2018, which indicated that the organization immediately investigated reports by staff under this policy, and third party reports of abuse or neglect.

Inspector #627 interviewed RPN #115 who stated that they had forwarded the email to the DOC and the ADOC, when they had received it from PSW #104. They further stated that they had not gone to see the residents identified in the email as they had taken PSW #104's account of the incident.

Inspector #627 interviewed the DOC, who stated that they would have received the email when they had returned to work, two days later; however; they had thought the email pertained to another incident and had not completed an investigation. [s. 23. (1) (a) (iii)]

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 every alleged, suspected or witnessed incident of neglect of a resident by the staff is investigated immediately, to be implemented voluntarily.

WN #5: 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 the home's policy titled "Zero Tolerance of Abuse and Neglect", was complied with.

During an interview, PSW #104 shared an email with Inspector #627, which documented allegations of neglect towards multiple residents. Please see WN #1, finding 1, A and B, for details.

Inspector #627 reviewed the home's policy titled "Zero Tolerance for Abuse and Neglect", last reviewed July 6, 2018, which defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents. Staff who reported that they had witnessed or suspected an alleged incident(s) of resident abuse or neglect were to immediately report to the ADOC, DOC or Administrator, and if it was after hours, to the RN in charge.

Inspector #627 interviewed PSW #104, who stated that they had brought forth their concern to RPN #114 and that they were directed to document their concerns in an email.

Inspector #627 interviewed RPN #114, who stated that PSW #104 had approached them with their concerns and they had asked them to document their concerns in an email which they would forward to management (DOC and ADOC). They further stated that they had mentioned to RN #110 that they had sent an email in regards to the lack of care provided to the residents and that RN #110 had not questioned them regarding the concerns brought forth. They stated that they had not called the on call manager at the time, because they wanted the concerns to be documented and for the DOC or ADOC to investigate and to submit a report to the Ministry if they felt it was warranted. RPN #114 acknowledged that this was neglect of the residents.

Inspector #627 interviewed the DOC, who stated that the RPN should have reported the concerns to the RN, or called the manager on call. [s. 20. (1)]

WN #6: 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 a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

During an interview, PSW #104 shared an email with Inspector #627 alleging neglect of multiple residents. Please see WN #1, finding 1, A and B, for details. PSW #104 stated that they had been asked by RPN #115 to document the concerns in an email and forward it to them, which they had done.

Inspector #627 reviewed the home's policy titled "Zero Tolerance for Abuse and Neglect", last revised July 6, 2018, which indicated that Section 24 (1) of the LTCHA required a person to make immediate reports to the Director where there was a reasonable suspicion of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspector #627 interviewed RPN #115 who stated that they had forwarded the email to the DOC and the ADOC, on the day that they had received the email from PSW #104.

Inspector #627 interviewed the DOC who stated that they would have received the email when they had returned to work, two days later, however; they had thought the email pertained to another incident had not reported the incident to the Director. The DOC further acknowledged that this may have constituted neglect and should have been reported. [s. 24. (1) 1.]

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.