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
Apr 5, 2019	2019_772691_0001	032327-18, 001128-19, 002723-19, 003247-19	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

JENNIFER NICHOLLS (691), MICHELLE BERARDI (679)

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): March 25-29, 2019.

The following intakes were inspected upon during this Critical Incident System inspection:
-Four intakes were completed related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Nurses (RNs), Behavioural Supports Ontario (BSO), Registered Practical Nurse (RPN), Personal Care Assistants (PCAs), residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 Critical Incident System (CIS) report was submitted to the Director, on a specified date, related to an incident of, or an allegation of, resident to resident abuse.

A review of the CIS report indicated that resident #005 entered resident #004's room. Resident #004 began exhibiting responsive behaviors towards resident #005, which caused injury to resident #005.

Inspector #691 reviewed resident #004's health care record and identified a progress note which indicated that as a result of the responsive behavior, a new identified intervention was implemented for resident #004. Inspector #691 reviewed resident #004's plan of care, which indicated the specified intervention was to be in place when resident was in their room.

Inspector #691 observed the resident on identified dates, with a total of 11 occasions where resident #004 was in their room but the identified intervention was not in place.

Inspector #691 conducted observations of resident #004 with direct care staff member #100 and #101, and Registered staff member #102, on separate occasions and confirmed the specified intervention was not in place as set out in the plan of care.

Inspector #691 reviewed the policy titled "Careplanning", last reviewed November 28, 2018, which identified that the objective of the plan of care serves: "to communicate significant information about the resident/patient to the inter-professional team."

Furthermore, it was noted that the inter-professional team members were to "Provide care to the resident/patient as set out in the plan."

During an interview with direct care staff members #104, #106, and #107, they indicated that resident #004 was to have the specified intervention in place when the resident was in their room.

During an interview with Registered staff member #102, and #103, they confirmed the expectation at a minimum was that the specified intervention was in place when resident #004 was in their room.

During an interview with the Director of Care (DOC), Inspector #691 reviewed the plan of care for resident #004, and the DOC confirmed that the expectation was that resident #004 should have had the specified intervention in place when resident when was in their room. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director, in response to resident #001 exhibiting responsive behaviors towards resident #002 that caused resident #002 to fall and sustain an injury.

A) Inspector #691 reviewed resident #001's progress notes, which indicated resident #001 had a specified type of assessment initiated on a identified date.

Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on five occurrences during the specified period of time.

B) Inspector #691 reviewed a progress note one day after the Inspector's review period which indicated a new specified type of assessment. Inspector #691 reviewed the residents specified type of assessment for a period of seven days and identified missing documentation on three occurrences during the specified period of time.

C) Inspector #691 reviewed progress notes three days after the Inspector's second review period, which indicated new specified type of assessment was initiated for resident #001. Inspector #691 reviewed the specified type of assessment for a period of

seven days and identified missing documentation on three occurrences.

Inspector #691 reviewed a specific policy last revised December 7, 2018. The policy indicated that staff would participate in the documentation that was required for any assessment of the resident.

Inspector #691 interviewed direct care staff member #107, who indicated that residents who required the specified type of assessment had documentation completed for an identified period of time, and further indicated that there was missing documentation.

Inspector #691 interviewed Registered staff member #103, who indicated that any staff member including direct care staff members could document using the specified type of assessment.

Inspector #691 interviewed direct care staff member #107, and Registered staff member #103 who reviewed the specified type of assessment for resident # 001, and confirmed missing documentation, which indicated that staff did not complete as required.

Inspector #691 interviewed the DOC, who verified that all staff were trained on documentation and could document on the specified type of assessment. The DOC confirmed that it was the expectation that any staff member working on the unit, implement the specified type of assessment and document as indicated. The DOC confirmed the specified type of assessment be implemented and documentated as indicated. The DOC confirmed the expectation was that, when a resident required this specified type of assessement, that it would be completed. The DOC acknowledged that specified intervention for resident #001 was not completed as was required. [s. 6. (9) 1.]

3. Inspector #691 reviewed resident #007's progress notes, which indicated this resident had a specific type of assessment initiated on an identified date. The Inspector reviewed the resident's specified type of assessment for a period of seven days, and identified missing documentation on two occasions.

The Inspector reviewed the home's "Documentation" policy, last revised June 1, 2018. The policy indicated that staff would participate in documenting in the resident health record accurately and timely.

The Inspector interviewed direct care staff member #107, who indicated that residents who required the specified type of assessment had the documentation completed for an

identified period of time, and further indicated that there was missing documentation.

Inspector #691 interviewed Registered staff member #103, who indicated that any staff member, including a direct care staff member, could document using the specified type of assessment.

Inspector #691 interviewed direct care staff member #107, and Registered staff member #103 who reviewed the specific type of assessment for resident #007, confirmed missing documentation which indicated that staff did not complete as required.

Inspector #691 interviewed the DOC, who verified that all staff were trained on documentation and could document on the specified type of assessment. The DOC confirmed that it was the expectation that any staff member that worked on the unit, implement the specified type of assessment and document as indicated. The DOC confirmed the expectation was that, when a resident required this specified type of assessment, that it would be completed. The DOC acknowledged that the specified type of assessment for resident #007 was not completed as required. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the provision of care set out in the plan of care, is documented, to be implemented voluntarily.

Issued on this 15th day of April, 2019

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

Original report signed by the inspector.