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
Jun 11, 2019	2019_668543_0013	005584-19, 005956-19, 006115-19, 008727-19, 009309-19, 009363-19	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

TIFFANY BOUCHER (543), AMY PAGE (749)

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): June 4-7 and 10, 2019.

The following intakes were inspected during this Critical Incident System Inspection:

-one intake, related to abuse;

-three intakes, related falls;

-one intake, related to responsive behaviours; and

-one intake, related to improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW) and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The home submitted two Critical Incident System (CIS) reports to the Director for incidents of alleged abuse. The first CIS report was submitted on a specific date in 2019, which identified that resident #002 was found in resident #003's room. The report identified that resident #003 displayed responsive behaviours towards resident #002. The second CIS report was submitted on a different day in 2019, which stated that there was an unwitnessed incident on a specific day in 2019, where resident #003 injured resident #006.

A) Inspector #749 reviewed resident #003's progress notes and Physician orders, which indicated an intervention, related to the resident's responsive behaviours was initiated after the incident that occurred on a specific day in 2019.

Inspector #749 reviewed the documentation for resident #003's responsive behaviour intervention, for two separate weeks in 2019, and noted missing documentation on ten different days.

B) Inspector #749 reviewed resident #006's progress notes, which indicated that an intervention was initiated on a specific date in 2019, related to the resident's responsive behaviours.

Inspector #749 reviewed the documentation for resident #006's responsive behaviours, for six days in 2019, and noted missing documentation on five separate days.

C) Inspector #749 reviewed resident #007's progress notes, which indicated that an intervention was initiated on a specific date in 2019, related to the resident's responsive behaviours.

Inspector #749 reviewed the documentation record for resident #007's responsive behaviours, for 11 days in 2019, and noted missing documentation on four separate days.

Inspector #749 reviewed home's policy titled "Documentation", last revised on June 1, 2018. The policy identified under the heading "Documentation Standards", that documentation provided evidence that care requirements had been met and that interventions of team members had been delivered.

In an interview with Inspector #749, PSW #102 identified that staff were to document the outcome of the intervention on the record. Together, Inspector #749 and PSW #102 reviewed the documentation record for resident #003, #006 and #007. PSW #102 confirmed that the documentation was incomplete.

In an interview with Inspector #749, RPN #101 identified that documentation related to the outcome of the intervention was supposed to be completed. Together, Inspector #749 and RPN #101 reviewed the documentation record for resident #003, #006, and #007. RPN #101 confirmed that the documentation was incomplete.

Inspector #749 interviewed RN #103, who stated that the documentation record was to be completed, and then the record was assessed by the Physician. Together, Inspector #749 and RN #103 reviewed the documentation record for resident #003, #006, and #007. When RN #103 was asked if all the documentation on the specific records should have been completed, RN #103 replied "Yes, they should have been completed". [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.