Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 1, 2021	2021_901759_0006	007719-21	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

KEARA CRONIN (759)

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): August 23-27 and 30, 2021.

The following intake was inspected upon during this Complaint Inspection:

- One intake related to concerns regarding a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA), Environmental Services Manager, Housekeepers, residents, and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed cooling and air temperature requirements, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 a resident received continence care as specified in their plan of care.

A resident's care plan outlined directions for staff to provide continence care to the resident.

A PCA did not provide continence care to a resident as outlined in their plan of care.

The DOC indicated that the PCA did not follow the resident's plan of care specific to continence care.

As a result, these actions posed a risk to the resident's safety during care that was provided.

Sources: interviews with a PCA, the DOC, and other relevant staff; a resident's care plan; the homes investigation notes; A coaching letter addressed to a PCA. [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 resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PCA used safe transferring techniques while assisting a resident using a mechanical lift.

The homes policy titled “Lifts and Transfers: Minimal Lifts” indicated that two staff must be present at all times when utilizing mechanical lifts.

A PCA indicated that they had transferred a resident using a mechanical lift without the assistance of a second staff member. They also indicated that they did this when they were short staffed.

Although there was no harm identified to the resident as a result of these actions, the PCA's actions placed the resident at a risk of injury since two staff are required for mechanical lifts.

Sources: Policy titled “Lifts and Transfers: Minimal Lifts”; a Coaching letter addressed to a PCA; interview with a PCA and other relevant staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medicated creams were stored in an area that was secured and locked.

On one occasion, a storage bin that contained various medicated creams was observed on a desk that was accessible to anyone, including residents. There was risk identified as residents had the ability to access the medicated creams.

The lid of the bin indicated to store all prescribed treatment creams in the med cart or treatment cart bin located in the medication room, separate from the oral medication.

Sources: Inspector #759's observations on August 27, 2021 and the policy titled "The Medication Storage". [s. 129. (1) (a) (ii)]

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 stored in an area or medication cart, that is secure and locked, to be implemented voluntarily.

Issued on this 7th day of September, 2021

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

Original report signed by the inspector.