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
Nov 10, 2021	2021_895609_0003	013367-21	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

KAREN HILL (704609)

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): November 1-3, 2021.

The following intake was inspected upon during this Critical Incident System inspection:
- one log related to resident to resident abuse.

Inspector #692 attended this inspection as an observer.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC)/Infection Prevention and Control (IPAC) lead, COVID-19 surveillance assistants, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Assistants (PCAs), Housekeepers, visitors and residents.

The inspector also conducted a daily tour of resident home areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed staff and residents IPAC practices, reviewed relevant resident health records, relevant staffing schedules, and the licensee and home's policies/procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, specifically related to staff wearing face masks.

COVID-19 Directive #3, indicates that all staff must comply with universal masking and must wear a medical mask for the entire duration of their shift, even when they were not delivering direct resident care.

During the inspection, the Inspector noted two staff members not wearing a mask properly while on the home area and while exiting a resident room with additional precautions posted.

There was minimal risk of harm to the residents by the staff members not wearing their mask as directed.

Sources: COVID-19 Directive #3 for Long-Term Care Homes under the LTCHA, 2007 and issued under Section 77.7 of the HPPA, R.S.O. 1990, c.H.7, in effective as of July 16, 2021; Inspector observations; licensee "COVID-19 Management Guidelines" (updated October 27, 2021); interviews with the ADOC/IPAC lead and other staff. [s. 5.] [s. 5.]

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 is a safe and secure environment for its residents, specifically to ensure staff comply with universal masking, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the IPAC program, specifically related to wearing the appropriate Personal Protective Equipment (PPE).

The Inspector observed signage on a resident's door that indicated that staff were to apply specified PPE. A staff member was observed exiting the room with their mask below their chin and did not have any other PPE. In an interview with the staff member, they indicated they had not put on the required PPE when entering the room to provide care.

Public Health Ontario's document, "Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition" dated November 2012, indicated that in non-acute settings there were specific PPE to be worn dependent upon the additional precautions required.

During an interview with the ADOC/IPAC lead for the home, they verified staff were to wear a mask at all times. They indicated that staff were to use additional PPE when a resident had additional precautions in place.

Sources: Observations of the RPN, signage on resident's door; PHO, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012; the licensee policy titled "Personal Protective Equipment (PPE) and Routine Practices: In the Clinical Setting", last reviewed April 27, 2012; interviews with the ADOC/IPAC lead and other staff. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

During the inspection, signage related to additional precautions was observed on a resident's door. The signage did not indicate when additional precautions were to be taken. The resident's care plan did not include direction related to additional precautions.

An RPN working on the unit and the ADOC/IPAC lead verified additional precautions were required. They confirmed that the plan of care for the resident did not set out clear directions to staff and others who provided care to the resident related to the additional precautions needed and when to implement them.

The care plan had not set out clear directions to staff which may have resulted in the incorrect Personal Protective Equipment (PPE) being worn by staff when required.

Sources: Inspector's observations, signage on the resident's door, review of the resident's progress notes and care plan, interviews with RPNs, the ADOC/IPAC lead and other staff. [s. 6. (1) (c)]

Issued on this 10th day of November, 2021

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

Original report signed by the inspector.