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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
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Original Public Report

Report Issue Date July 6, 2022
Inspection Number 2022_1397_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's Health Centre of Sudbury

Long-Term Care Home and City
St. Joseph's Villa, Sudbury

Lead Inspector
Steven Naccarato (744)

Additional Inspector(s)
Ryan Goodmurphy (638)

Inspector Digital Signature
Steven C Naccarato
Digitally signed by Steven C Naccarato
Date: 2022.07.18 09:22:10 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20-24, 2022.

The following intake(s) were inspected:

- One intake related to staff to resident neglect;
- Two intakes related to an injury that caused a significant change in health status;
- One intake related to an unexpected death; and,
- One intake related to a complaint regarding care and safety concerns of a resident.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Recreational and Social Activities
- Responsive Behaviours

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WRITTEN NOTIFICATION - DUTY TO PROTECT

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 19. (1)

The licensee has failed to ensure that a resident was protected from neglect by a PCA (Personal Care Assistant).

Rationale and Summary
A RPN (Registered Practical Nurse) identified that a resident had not been provided with the proper care.

Internal investigation notes identified that a PCA admitted to not providing care to the resident because they were busy with other residents.

There was moderate harm to the resident.

Sources: The home's internal investigation notes; the CIS (Critical Incident System) report; the resident's electronic health care records; the home's policy, "Zero tolerance of abuse and neglect", last revised April 8, 2022; Interview with a RPN and other staff members.

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WRITTEN NOTIFICATION – PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6. (7)

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

Rationale and Summary
A resident's plan of care indicated that they preferred to be assisted with a specific care at a specific time.

A PCA indicated that the resident was not assisted with that specific care at the time preferred.

The impact of the resident not assisted with their preferred care was low.

Sources: The home's internal investigation notes; the CIS report; the resident's electronic health care records; Interview with a PCA and other staff members.

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WRITTEN NOTIFICATION - SKIN AND WOUND CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 50 (2) (a) (ii)*

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, upon their return from hospital.

Rationale and Summary
A resident was sent to hospital after a fall that resulted in an injury. Registered staff outlined that upon a resident's return from hospital, they should receive a head-to-toe skin assessment that was documented electronically in Point Click Care under assessments. There was no record of a head-to-toe skin assessment completed for the resident after their return from hospital.

Staff failure to complete the head-to-toe skin assessment placed the resident at risk of having any potential skin integrity concerns not being identified or managed at the time of their return.

Sources: The resident's health care records including progress notes, census and Point Click Care assessments; the home's policy titled "Wound and Skin Care Program" last reviewed April 1, 2022; and interviews with the ADOC and other staff.

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