Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: May 31, 2023	
Inspection Number: 2023-1397-0004	
Inspection Type: Complaint	
Licensee: St. Joseph's Health Centre of Sudbury	
Long Term Care Home and City: St. Joseph's Villa, Sudbury, Sudbury	
Lead Inspector Chad Camps (609)	**Inspector Digital Signature** Chad A Camps Digitally signed by Chad A Camps Date: 2023.06.07 08:37:10 -04'00'
Additional Inspector(s) Barbara Humenjuk (000741)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15-19, 2023. The following two intakes were inspected:

- Two intakes related to concerns about the operation of the home and the care of a resident.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance (NC) was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that a resident's written plan of care set out the planned care for the resident.

Rationale and Summary

A resident was known to remove a specified intervention and staff were to check that the intervention was in place.

Registered staff verified that the resident removed the specified intervention and that it should have been documented in the resident's plan of care to ensure staff checked that it was in place.

However, the resident's plan of care found no mention that the resident removed the specified intervention.

The home's failure to ensure that the resident's plan of care set out the planned care for the resident presented low risk to the resident as the staff were aware the resident removed the specified intervention and the Responsive Behaviour (RB) Lead immediately updated the resident's plan of care.

Sources: A resident's health care records and plan of care report; The home's policy titled "Care Plans" last reviewed April 1, 2022; Interviews with the RB Lead and other staff. [609]

Date Remedy Implemented: May 19, 2023

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the door to cleaning room #N260 was kept closed and locked when not being supervised by staff.

Rationale and Summary

The door to cleaning room #N260 was found unlocked, unattended, and propped open with a door stopper. Various bottles of chemicals were being stored inside.

Environmental Services staff verified that the door to #N260 should have been locked when unattended.

The home's failure to ensure that the door to cleaning room #N260 remained locked when not in attendance by staff presented moderate risk of harm to residents who could have entered the room.

Sources: Inspector's observations on a home area; The home's policy titled "Door Locking" last reviewed March 7, 2023; Interviews with the MM and other staff. [609]

WRITTEN NOTIFICATION: Mobility Devices

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 43

The licensee has failed to ensure that mobility devices were always available to a resident on a short-term basis.

Rationale and Summary

Staff of the home became aware that a piece of a resident's equipment was unsafe, but the MM was not alerted to assess the resident's unsafe piece of equipment and exchange it for an alternative until the resident's could be repaired.

The home's failure to ensure that the resident had access to an alternative piece of equipment until their own was repaired caused moderate harm to the resident who sustained an injury as a result.

Sources: A resident's health care records; Equipment work orders; Interviews with the Administrator and other staff. [609]