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: November 3, 2023

Inspection Number: 2023-1397-0005

Inspection Type:
Complaint
Critical Incident

Licensee: St. Joseph's Health Centre of Sudbury

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

Lead Inspector	**Inspector Digital Signature**
Samantha Fabiilli (000701)	Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2023.11.10 09:47:30 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25 to 29, 2023

The following intake(s) were inspected:
- One intake related to resident care.
- One intake related to improper/incompetent treatment of a resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was reviewed and revised when a resident's care needs changed.

Rationale and Summary:

A staff member indicated that a resident's care needs had changed, as well as indicated they were not aware of a schedule related to a specific care need. Another staff member also confirmed the change in a resident's care needs.

A resident's current care plan indicated care needs that were not accurate to the care being provided. The care plan also indicated that care for a specific care need was to be provided as per a schedule. However, this schedule was not included in the resident's plan of care.

The DOC (Director of Care) confirmed a resident's care needs that was outlined in their care plan. The DOC indicated that it was their expectation a care plan be updated when a resident's care needs change.

Sources: Interviews with Staff and DOC; Review of a resident's current care plan; Review of a resident's POC.
[000701]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that they immediately forwarded to the Director any written complaint it received concerning the care of a resident.

Rationale and Summary:
The home received a complaint to which they responded to the complainant on the same day. However, the home did not immediately submit a Critical Incident report until one day after the complaint was received.

The DOC indicated that they did not consider the complaint received to meet the criteria for reporting to the Director, at the time of receipt. However, an internal communication was sent by the DOC to staff of the home prior to the complaint being received, indicating concerns related to the care of a resident and a request for interventions to be implemented in relation to this.

There was low impact and low risk to a resident as a result of this late reporting, as the home took action to implement interventions related to a complainant's concerns.

Sources: A Critical Incident Report; Written records from a complainant and DOC; Interview with DOC. [000701]