

**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**

<b>Report Issue Date:</b> February 8, 2024	
<b>Inspection Number:</b> 2024-1397-0001	
<b>Inspection Type:</b> Complaint Critical Incident	
<b>Licensee:</b> St. Joseph's Health Centre of Sudbury	
<b>Long Term Care Home and City:</b> St. Joseph's Villa, Sudbury, Sudbury	
<b>Lead Inspector</b> Sylvie Byrnes (627)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Loviriza Caluza (687) Shelley Murphy (684)	

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 18-19, and 22-26, 2024.

The following intake(s) were inspected:

- Intake #00100620/CIS #2913-000025-23, related to a Covid-19 outbreak;
- Intake #00100662/CIS #2913-000027-23, related to the conduct of a visitor; and,
- Intake #00101371, a complaint related to abuse of a resident.

**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

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

- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting and Complaints

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

**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

### Rational and Summary

**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

A Covid-19 outbreak was declared in the home, by the Public Health Unit (PHU) on October 24, 2023, but was only reported to the Director on October 30, 2023, six days after the outbreak was declared. The Infection Prevention and Control (IPAC) lead and the Administrator acknowledged that the incident should have been reported on October 24, 2023, when the outbreak was declared.

There was low risk of harm to residents when the Covid-19 outbreak was reported late.

**Sources:** Interviews with Administrator and IPAC lead, record review of Critical Incident System (CIS) report #2913-000025-23 and home's policy titled, "Critical Incident Reporting and Review", issued September 29, 2003. [627]