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 3, 2024

Inspection Number: 2024-1397-0003

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**
Charlotte Scott (000695)	Charlotte A Scott Digitally signed by Charlotte A Scott Date: 2024.05.24 11:58:50 -04'00'

Additional Inspector(s)
Chad Camps (609)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18-22, 2024
The inspection occurred offsite on the following date(s): March 25, 2024

The following intake(s) were inspected:

- Two intakes related to incidents of a missing resident for less than 3 hours;
- One complaint submitted to the Director related to outbreak management and communication;
- One complaint submitted to the Director related to air temperatures in the home.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Air Temperature

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
Air temperature logs identified temperature measurements in resident rooms below 20 degrees Celsius.

The home required low temperature measurements to be reported to the Environmental Services Manager (ESM), investigated and if possible fixed. However, the home was unable to provide a record of how or when the continued low temperatures measurements were remedied.

The home's failure to maintain the air temperature at a minimum 22 degrees Celsius impacted residents who experienced low room temperatures.

Sources: Resident Council meeting minutes; Air temperature logs; Air temperature instruction document; interview with the Administrator.
[609]

WRITTEN NOTIFICATION: Air Temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
Air temperature logs identified gaps in temperatures being measured and recorded.

The home's Administrator verified that air temperatures should have been measured and documented in at least two resident bedrooms in different parts of the home three times per day.

The home's failure to measure and document air temperatures in at least two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night presented low risk of harm to the residents.

Sources: Air temperature logs; Air temperature instruction document; interviews with Maintenance staff and the Administrator.
[609]

WRITTEN NOTIFICATION: Hazardous Substances

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances in the home were kept inaccessible to residents at all times.

Rationale and Summary
During the inspection, a housekeeping cart was observed left out and unsecured, accessible to anyone walking by.

The Director of Care (DOC) indicated that housekeeping cleaning products and supplies were to be kept in locked rooms on the units, and stated that housekeeping carts had locking mechanisms. The DOC confirmed the cleaning products on housekeeping carts were considered hazardous substances, and

residents should not have had access to them.

There was risk to residents when the housekeeping cart containing hazardous substances was left unattended and unsecured, leaving the products accessible to residents.

Sources: Inspector observation; policy titled "Hazardous Substance Control" issued May 1, 2012, last reviewed July 7, 2023; and interviews with the DOC, and the staff member.
[000695]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident.

The licensee has failed to ensure that the name of the staff who discovered an incident was included in the Critical Incident (CI) report submitted to the Director.

Rationale and Summary
A CI report was submitted to the Director, however, the Assistant Director of Care

(ADOC) verified that the staff member who discovered the incident was not included in the report.

Sources: Point of Care (POC) Audit report for the resident; the CI report; the home's policy titled "Critical Incident Reporting & Review" last reviewed April 24, 2023; and interviews with the staff member and ADOC.
[609]

COMPLIANCE ORDER CO #001 Policies, etc., to be followed, and records

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement an auditing system to ensure that required visual checks are completed and documented for residents;

b) Document the audits and ensure that these audits include the date, time, name, and signature of the staff member conducting the audits;

c) Document any immediate corrective action if the required visual checks are not completed and/or documented;

d) Conduct the audits for four weeks or longer if continued concerns are identified; and,

e) Maintain all documentation of the audits and make available to the Inspector(s) upon request.

Grounds
The licensee has failed to ensure that where the Act required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee was required to ensure that the program was complied with.

Rationale and Summary
Pursuant to the Fixing Long-Term Care Act (FLTCA) 2021, section (s.) 11 (1) (b) the licensee was to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

On an identified date, a resident eloped from the home. Staff routines required staff to check on residents at least twice in the shift at specified times.

The staff responsible for the resident on the identified date did not complete the checks during their shift.

The home's failure to ensure that the staff fulfilled the required shift routine presented risk of harm to the resident.

Sources: CI report; Personal Care Assistant: Routine; interview with the Assistant Director of Care (ADOC).
[609]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

Develop and implement an auditing process and complete the audit(s) weekly for each unit inclusive of all departments and shifts, to ensure:
a) all staff and students comply with applicable masking requirements as required;
b) all resident rooms identified under additional precautions have the appropriate signage, and, that all required PPE is available at the point of entry to the identified rooms;
c) all staff and students are appropriately donning and doffing the required PPE for

rooms identified under additional precautions;
d) shared resident equipment is cleaned and disinfected between each resident use; and,
e) that hand hygiene is being completed by all staff and students as per the home's hand hygiene policy.

The audit(s) shall occur for a period of four weeks. The IPAC Lead shall analyze the results of the audit(s), identify trends, and provide retraining to correct any deficiencies. Documentation of the audits, completed analysis, and any corrective action implemented must be maintained and made available to the Inspector(s) upon request.

Grounds
The licensee failed to ensure there was in place an outbreak management system for detecting, managing, and controlling infectious disease outbreaks.

Rationale and Summary
The home's outbreak status at the time of inspection included two outbreak types affecting multiple units in the home.

a) At the time of inspection, universal masking was in place on the identified units.

Multiple staff from different departments were observed not following the masking protocols in place.

The DOC and IPAC Lead confirmed that universal masking was in place for the identified units on outbreak.

b) Two resident rooms were observed having PPE available at point of care

however, there was no signage indicating the purpose of the PPE.

The IPAC Lead confirmed additional precaution signage should have been on resident doors in coordination with PPE supplies.

c) Multiple resident rooms were observed with additional precaution signage, however, PPE was not available at the point of entry to the rooms.

The IPAC Lead indicated that all required PPE should have been available for use at the point of care.

d) A room was observed with signage on the door identifying additional precautions were in place, with PPE available. Multiple staff were observed in the room without the required PPE.

Another room was observed to have signage indicating additional precautions were in effect. It was observed that not all PPE was doffed upon exit of the room, and that not all of the required PPE was donned as required upon entrance to the room.

The IPAC Lead confirmed staff were to don and doff PPE for the identified room.

e) Multiple shared resident equipment items were observed not being cleaned or disinfected after use.

The IPAC Lead indicated that shared equipment was to be sanitized between each resident use.

f) Multiple staff were observed not completing hand hygiene when required.

The IPAC Lead confirmed that hand hygiene was required by staff before resident contact.

There was actual risk of transmission of pathogens to residents when the licensee did not ensure that the systems in place were effective in managing and controlling the infections disease outbreaks.

Sources: Inspector observations; email communication from IPAC Lead, policy titled "Initiating Isolation and Additional Precautions" issued January 2004, policy titled "Hand Hygiene" issued June 1, 2009, last revised January 19, 2024; and interviews with the IPAC Lead, DOC, and other staff.
[000695]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #003 Doors in a home

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a daily auditing process which will include weekends, holidays and varying shifts, to ensure that all doors leading to non-residential areas are kept closed and locked when not being directly supervised by staff;

b) Document the daily audits and ensure that these audits include the date, time, name, and signature of the staff member conducting the audits;

c) Take immediate corrective action if doors are found to be unlocked and not directly supervised by staff and document within the daily audits any corrective actions taken, including following up with staff who are responsible for locking the door(s);

d) Conduct the daily audits for four weeks or longer if continued concerns are identified;

e) Maintain all documentation of the daily audits and make available to the Inspector(s) upon request.

Grounds
The licensee has failed to ensure that three non-resident rooms in the home were kept locked when not supervised by staff.

Rationale and Summary
a) During the inspection multiple doors leading to non-residential areas were found unlocked and unattended by staff.

The Administrator verified that the doors were not locked.

The home's failure to ensure that multiple doors to non-resident areas were kept locked when not attended by staff presented moderate risk to residents who could have entered these areas with long-standing broken keypads.

Sources: The home's policy titled "Door Locking" last reviewed March 7, 2023; Inspection Report #2023_1397_0006 issued December 19, 2023; Inspector's observations; interviews with the Administrator and other staff.
[609]

This order must be complied with by June 28, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.