Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_099188_0028
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Jul 31, Aug 1, 9, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST. JOSEPH'S VILLA, SUDBURY 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNE PALKOVITS

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall review and revise the written plan of care for residents #841 and #872. Their plans of care shall set out clear direction to staff and others who provide direct care to the residents. The licensee shall ensure that residents are reassessed and their plans of care reviewed and revised at any time their care needs change. The licensee shall ensure that staff and others involved in the different aspects of care of the residents collaborate with each other in the development and implementation of their plan of cares so that the different aspects of care are integrated and are consistent with and complement each other.

Grounds / Motifs :

1. (188)
2. Inspector reviewed the health care record including plan of care for resident #872. Inspector noted this resident has previously accused staff and other residents of verbal abuse. Inspector noted these allegations were unfounded. Inspector reviewed the resident's progress notes which identified episodes of this behaviour and the inspector spoke with various staff members who were aware of this behaviour. Inspector noted the plan of care did not include the resident's paranoid behaviour or provide any interventions directing staff how to respond. The licensee failed to ensure the plan of care includes clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
3. Inspector reviewed the health care record including plan of care for resident #841 on July 31, 2012. Inspector noted this resident has sustained falls following physical altercations. Inspector reviewed the MDS assessment noting that it identifies the resident as exhibiting physically abusive behaviour symptoms and that the behaviour was not easily altered. Inspector reviewed the plan of care and noted the resident's physically responsive behaviour was not included. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [LTCHA 2007, S.O. 2007, c.8, s.6(4)(b)] (188)
4. Inspector reviewed the health care record including plan of care for resident #841 on July 31, 2012. Inspector reviewed the resident's progress notes. Inspector noted several episodes of physical aggression towards staff or other residents. Inspector spoke with staff on the unit who also identified the resident easily becomes frustrated and aggressive towards staff and other residents. Inspector reviewed the plan of care and noted the resident's physical aggression is not included. Inspector noted the plan of care contained no direction to staff on how to intervene should the resident display physical aggression. The licensee failed to ensure the plan of care includes clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
5. Inspector reviewed the health care record of resident #710 on July 31, 2012. Inspector noted a progress note entry that identified the resident's substitute decision-maker consented to a change in the resident's plan of care relating to fall prevention. Inspector noted the progress note entry identifies the plan of care will be updated to reflect this change. Inspector review the resident's plan of care noting that it had not been updated. The licensee failed to ensure that the plan of care is reviewed and revised at any time when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)] (188)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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Ministère de la Santé et des Soins de longue durée

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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of August, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'Inspection	Type of Inspection/Genre d'inspection
Jul 31, Aug 1, 9, 2012	2012_099188_0028	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

Long-Term Care Home/Foyer de soins de longue durée

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

Name of Inspector(s)/Nom de l'Inspecteur ou des inspecteurs

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the Inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), the registered nursing staff (RN/RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions and reviewed health care records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Inspector reviewed the health care record of resident #710 on July 31, 2012. Inspector noted a progress note entry that identified the resident's substitute decision-maker consented to a change in the resident's plan of care relating to fall prevention. Inspector noted the progress note entry identifies the plan of care will be updated to reflect this change. Inspector review the resident's plan of care noting that it had not been updated. The licensee failed to ensure that the plan of care is reviewed and revised at any time when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]
2. Inspector reviewed the health care record including plan of care for resident #841 on July 31, 2012. Inspector reviewed the resident's progress notes. Inspector noted several episodes of physical aggression towards staff or other residents. Inspector spoke with staff on the unit who also identified the resident easily becomes frustrated and aggressive towards staff and other residents. Inspector reviewed the plan of care and noted the resident's physical aggression is not included. Inspector noted the plan of care contained no direction to staff on how to intervene should the resident display physical aggression. The licensee failed to ensure the plan of care includes clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
3. Inspector reviewed the health care record including plan of care for resident #841 on July 31, 2012. Inspector noted this resident has sustained falls following physical altercations. Inspector reviewed the MDS assessment noting that it identifies the resident as exhibiting physically abusive behaviour symptoms and that the behaviour was not easily altered. Inspector reviewed the plan of care and noted the resident's physically responsive behaviour was not included. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [LTCHA 2007, S.O. 2007, c.8, s.6(4)(b)]
4. Inspector reviewed the health care record including plan of care for resident #872. Inspector noted this resident has previously accused staff and other residents of verbal abuse. Inspector noted these allegations were unfounded. Inspector reviewed the resident's progress notes which identified episodes of this behaviour and the inspector spoke with various staff members who were aware of this behaviour. Inspector noted the plan of care did not include the resident's paranoid behaviour or provide any interventions directing staff how to respond. The licensee failed to ensure the plan of care includes clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE ORDER(S) / REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDRES

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001, #002, #003, #004	2012_138151_0013	188
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001, #002, #003, #004	2012_138151_0013	188
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001, #002, #003, #004	2012_138151_0013	188
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001, #002, #003, #004	2012_138151_0013	188

Issued on this 10th day of August, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs