Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Nov 25, 2013;	2013_138151_0032 (A1)	S-000955-12,S-00161,121,408-13	Critical Incident

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

MONIQUE BERGER (151) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changes to the original order have been made according to discussion Friday November 22, 2013. It remains that the compliance date for the order is November 28, 2013.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 25 day of November 2013 (A1)

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

Monique G. Berger (151)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : MONIQUE BERGER (151) - (A1)

Inspection No. / No de l'inspection : 2013_138151_0032 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000955-12,S-00161,121,408-13 (A1)

Type of Inspection / Genre d'inspection: Critical Incident

Report Date(s) / Date(s) du Rapport : Nov 25, 2013;(A1)

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

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

Ministère 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

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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to all residents as specified in the plan of care: specifically as the plans of care relate to bathing, staff assistance in bathing process and the use of lifts and lap belts.

This plan is to be submitted to Inspector Monique Berger (151), Health System
Accountablity and Performance Division, Sudbury Service Area Office, 159 Cedar Street, Suite 403, Sudbury, ON P3E 6A5 by November 28,2013

Grounds / Motifs :

(A1)

1. Inspector conducted a Critical Incident inspection in relation to Resident #001 who sustained a fall while being bathed, was transferred to hospital for further assessment and treatment, subsequently diagnosed of a head injury and who died of this injury.

Inspector reviewed the bathing policy that was in place at the time of the incident and noted that it did not have explicit instructions for the use of lap belts with bathing devices such as bath shower chairs, bath lifts or stretchers.

In an interview, Director of Care (DOC) confirmed that a lap belt was not applied when the resident was being bathed on the day of the incident

Inspector reviewed the current bathing policy last revised October 4, 2013 noting this policy changed subsequent ot the in incident involving Resident #001. The policy is now explicit: "A lap belt is applied whenever a bathing device , such as shower chair, tube chair lift or tub stretcher lift is used".

Inspector interviewed staff in regards to current resident bathing practice. Staff stated awareness that residents should have lap belts applied to bathing lifts and chairs, however, they often bathe the resident without it because the belt is missing.

Inspector conducted an audit of bathing devices throughout the resident home areas bath and shower rooms. Audit showed that 9 of 19 or 47.3% of bathing shower chairs, tub chair lift or tub stretchers audited did not have a lap belt attached to or on the device. In only 2 of the 8 rooms inspected were spare lap belts found in the cupboards.

In an interview, Assistant Director of Care confirmed that on the day of the incident, Resident #001 was attended by 2 staff for the resident lift and transfer but attended by only one staff person during the shower. In review of the resident's plan of care, Inspector noted that under BATHING, staff were directed as follows: "two persons: total dependent".

The care set out in the plan of care was not provided to the resident as specified in the Plan (151)

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

Ministère 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 :

Nov 28, 2013

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 Director

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

Ministère 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 25 day of November 2013 (A1)

Signature of Inspector / Signature de l'inspecteur : Monique G. Berger (151)

Name of Inspector / Nom de l'inspecteur : MONIQUE BERGER

Service Area Office / Bureau régional de services : Sudbury

Ontario

Ministry of Health and Long-Term Care

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Nov 25, 2013;	2013_138151_0032 (A1)	S-000955-12,S-00161,121,408-13	Critical Incident

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

MONIQUE BERGER (151) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 7, 8, 12, 13, 2013

This Critical Incident inspection relates to the following:

S-000955-12 and related CI:2913-000025-12

S-000161-13 and related CI:2913-000016-13

S-000121-13 and related CI:2913-000013-13

s-000408-13 and related CI:2913-000027-13

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families

During the course of the inspection, the inspector(s)

- observed care and service delivery to residents

- reviewed resident health care records

- reviewed policies, procedures, programs and protocols in relation to the prevention and management of resident falls

- reviewed policies, procedures, programs and protocols in relation to the management of resident responsive behaviours

- toured the resident units several times per day

- audited tub room equipment

- reviewed policies and procedures related to resident bathing

- reviewed the home's records of staff education for the last 12 months in reference to prevention and management of resident falls, management of resident responsive behaviours and zero tolerance for abuse and neglect

- reviewed the home's zero tolerance for abuse policy

- reviewed the home's process for critical incident reporting

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

Inspector conducted a Critical Incident inspection in relation to Resident #001 who sustained a fall while being bathed, was transferred to hospital for further assessment and treatment, subsequently diagnosed of a head injury and who died of this injury.

* Inspector reviewed the bathing policy that was in place at the time of the incident and noted that it did not have explicit instructions for the use of lap belts with bathing devices such as bath/shower chairs, bath lifts or stretchers.

In an interview, Director of Care (DOC) confirmed that a lap belt was not applied when the resident was being bathed on the day of the incident

Inspector reviewed Resident #001's health care record and noted that in the plan of care, under BATHING, the following interventions were identified: " Use regular size (not bariatric) reclining shower chair - shared with LV [Lake View]. Apply seat belt".

Inspector reviewed the current bathing policy last revised October 4, 2013 noting this policy changed subsequent to the incident involving Resident #001. The policy is now explicit: "A lap belt is applied whenever a bathing device, such as shower chair, tub chair lift or tub stretcher lift is used".

Inspector interviewed staff in regards to current resident bathing practice. Staff stated awareness that residents should have lap belts applied to bathing lifts and chairs, however, they often bathe the resident without it because the belt is missing.

Inspector conducted an audit of bathing devices throughout the resident home areas bath and shower rooms. Audit showed that 9 of 19 or 47.3% of bathing/shower chairs, tub chair lift or tub stretchers audited did not have a lap belt attached to or on the device. In only 2 of the 8 rooms inspected were spare lap belts found in the cupboards.

** In an interview, Assistant Director of Care confirmed that on the day of the incident, Resident #001 was attended by 2 staff for the resident lift and transfer but attended by only one staff person during the shower. In review of the resident's plan of care, Inspector noted that under BATHING, staff were directed as follows: "two persons: total dependent".

The care set out in the plan of care was not provided to the resident as specified in the Plan

Additional Required Actions:

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector 151 reviewed a critical incident report (CIS) issued by the home to the Ministry informing of alleged staff to resident abuse. Inspector noted that the alleged abuse was not reported to the management of the home until 2 days after the incident. The CIS is recorded as having been sent to the Ministry 12 days after the report of alleged staff to resident abuse was reported to the home's management staff.

The licensee did not ensure a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident immediately reports this to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure it is immediately reported to the Director whenever the home has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Inspector 151 reviewed a critical incident report (CIS) issued by the home to the Ministry informing of alleged staff to resident abuse. Inspector noted that the alleged abuse was not reported to the management of the home until 2 days after the incident. The CIS is recorded as having been sent to the Ministry 12 days after the report of alleged staff to resident abuse was reported to the home's management staff. The home stated that Staff #00101 was witnessed to be verbally and physically abusing Resident #005. CI stated that investigation was underway. No further update or amendments in regards to the home's investigation of the allegation were forwarded to the Director.

In an interview during the inspection, DOC confirmed the following:
- the staff person was not available for management interview for a protracted time following the incident
- upon returning to the home after the leave, the staff person was interviewed
- the staff member received disciplinary actions for their conduct

In reference to abuse of a resident by anyone, the Licensee did not report to the Director the results of investigation undertaken and every action taken in in light of the results. [s. 23. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Ministry received a Critical Incident Report stating that Resident #002 had sustained a fall that required transfer to hospital for further assessment and treatment. The resident was diagnosed with a fracture.

Inspector reviewed the health care records for resident #002. Inspector noted the home does have a post-fall assessment instrument that is specifically designed for falls - however for Resident #002 and the fall referenced in the Critical Incident Report, the post-fall assessment was not completed. Only the section describing the incident was documented, the rest of the form remained blank.

The licensee did not ensure that when a resident has fallen, the resident is assessed and where the condition or circumstance warrants, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

Issued on this 25 day of November 2013 (A1)

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

Monique G. Berger (151)