



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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

Public Copy/Copie du public

| Report Date(s) / Date(s) du rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|--|---|---|--|
| Feb 9, 2017 | 2017_615638_0003 | 016862-16, 016864-16, 016865-16, 016867-16, 016869-16 | 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.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): January 23 - 27, 2017.

The following intakes were completed during this Follow-Up inspection;

- Order #001 of report #2016_320612_0007, which was related to staff not providing care as per the plan of care;**
- Order #002 of report #2016_320612_0007, which was related to staffing not meeting the care needs of the residents;**
- Order #003 of report #2016_320612_0007, which was related to incomplete resident specific bed rail assessments;**
- Order #004 of report #2016_320612_0007, which was related to the nutrition and hydration program; and**
- Order #005 of report #2016_320612_0007, which was related to the safe storage of drugs.**

A Complaint inspection was conducted concurrently with this inspection. For details, please refer to inspection report #2017_615638_0004.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, residents and their family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed licensee policies, procedures, programs, relevant training records and health care records.

The following Inspection Protocols were used during this inspection:

Medication

Minimizing of Restraining

Nutrition and Hydration

Sufficient Staffing



During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / DE L'INSPECTION | NO | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|------------------------------------|-----------------------------------|----|---------------------------------------|
| O.Reg 79/10 s. 129. (1) | CO #005 | 2016_320612_0007 | | 638 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (7) | CO #001 | 2016_320612_0007 | | 638 |
| O.Reg 79/10 s. 68. (2) | CO #004 | 2016_320612_0007 | | 638 |
| LTCHA, 2007 S.O. 2007, c.8 s. 8. (1) | CO #002 | 2016_320612_0007 | | 638 |



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| 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). | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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 O.Reg 79/10, s. 15. Bed rails



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Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During inspection #2016_320612_0007, compliance order (CO) #003 was served on May 31, 2016, whereby, the licensee was ordered to ensure that all direct care staff were trained related to the home's bed rails assessment, use of the bed rail system and risks associated with bed rail usage. This education was to have been completed by July 12, 2016.

In an interview with Inspector #638, PSW #101 stated that they had not received any formal training related to bed rails and expected that any monitoring, assessments and follow up related to the bed rail systems would be the role of the registered staff within the home.

Upon review of training records of all direct care staff related to the bed rail assessment, usage as well as risks associated with bed rail use. Inspector #638 was unable to locate any completed training for the PSWs working at the home.

In an interview with Inspector #638, the ADOC stated that the required training was provided only to the registered staff as they believed that registered staff were only required to know the assessments and requirements related to bed rail assessments. Upon review of order #003 with the ADOC and DOC it was determined that the home was required to train all staff who provide direct care to residents related to assessment, use of the bed rail system and risks associated with bed rail usage. The ADOC stated that the home did not complete the required training and all PSWs should have also been trained regarding bed rail assessments, usage and risk. [s. 15. (1) (a)]

Additional Required Actions:

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



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Issued on this 27th day of February, 2017

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

Original report signed by the inspector.



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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*

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**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : RYAN GOODMURPHY (638)

Inspection No. /

No de l'inspection : 2017_615638_0003

Log No. /

Registre no: 016862-16, 016864-16, 016865-16, 016867-16, 016869-16

Type of Inspection /

Genre

d'inspection:

Follow up

Report Date(s) /

Date(s) du Rapport : Feb 9, 2017

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.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Ray Ingriselli

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(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

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Order # /

Ordre no : 001

Order Type /

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

Linked to Existing Order /

Lien vers ordre existant: 2016_320612_0007, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
- (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
- (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Train all PSWs of the home related to the bed rail assessments, use of the bed rail system and risks associated with bed rail use.
2. Maintain a document of the required training, when it was completed, what staff completed the training and what the training entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During inspection #2016_320612_0007, compliance order (CO) #003 was served on May 31, 2016, whereby, the licensee was ordered to ensure that all direct care staff were trained related to the home's bed rails assessment, use of the bed rail system and risks associated with bed rail usage. This education was to have been completed by July 12, 2016.

In an interview with Inspector #638, PSW #101 stated that they had not received any formal training related to bed rails and expected that any monitoring, assessments and follow up related to the bed rail systems would be the role of the registered staff within the home.

Upon review of training records of all direct care staff related to the bed rail assessment, usage as well as risks associated with bed rail use. Inspector #638 was unable to locate any completed training for the PSWs working at the home.

In an interview with Inspector #638, the ADOC stated that the required training was provided only to the registered staff as they believed that registered staff were only required to know the assessments and requirements related to bed rail assessments. Upon review of order #003 with the ADOC and DOC it was determined that the home was required to train all staff who provide direct care to residents related to assessment, use of the bed rail system and risks associated with bed rail usage. The ADOC stated that the home did not complete the required training and all PSWs should have also been trained regarding bed rail assessments, usage and risk.

During previous inspections (#2016_320612_0007) a compliance order was served on May 31, 2016, related to LTCHA, 2007, s. 15 (1). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm and although the scope was isolated, there is a compliance history including one compliance order previously issued in this area of the legislation. (638)



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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
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This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017



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Ordre(s) de l'inspecteur

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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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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.



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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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 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.



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Ordre(s) de l'inspecteur

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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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 February, 2017

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Ryan Goodmurphy

Service Area Office /

Bureau régional de services : Sudbury Service Area Office