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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2019	2019_655679_0005	032904-18, 000407-19, 002251-19	Critical Incident System

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

MICHELLE BERARDI (679), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19 to 21, 2019.

The following intakes were inspected upon during this Critical Incident System Inspection:

- One intake regarding a resident fall; and,
- Two intakes regarding resident to resident physical abuse.

A Complaint Inspection #2019_655679_0006 and a Follow Up Inspection #2019_655679_0004 were conducted concurrently with this Inspection.

Inspector #749 was present throughout the Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Personal Care Assistants (PCAs), Scheduling Clerks, Housekeepers, residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Two Critical Incident (CI) reports were submitted to the Director for incidents of resident to resident abuse. The CI reports identified that resident #002 performed an action towards residents #003 and #004, resulting in injury.

A) A review of the progress notes and the CI report identified that a specified type of assessment was initiated for resident #002 on specified dates.

Inspector #679 reviewed the assessment charting record for resident #002 for a specified period and noted missing documentation on eight dates.

B) Inspector #679 reviewed assessment charting record for resident #003 for a specified period of time and note missing documentation on five dates.

C) A review of the progress notes and CI report identified that a specified type of assessment was initiated for resident #004 on specified dates.

Inspector #679 reviewed the assessment charting record for resident #002 for a specified period and noted missing documentation on three dates.

A review of the policy titled "Documentation" last revised June 1, 2018, identified that documentation provided evidence that care requirements had been met and that interventions of team members had been delivered.

In an interview with Inspector #679, PSW #102 identified that staff were to document on the resident at specified intervals on the assessment charting record. Together, Inspector #679 and PSW #102 reviewed the assessment charting record. PSW #102 confirmed the document should have been completely filled out.

In an interview with Inspector #679, RPN #104 identified that the specified assessment was initiated under certain circumstances. Together, Inspector #679 and RPN #104 reviewed the assessment charting record. RPN #104 confirmed the document should have been completely filled out.

In an interview with the DOC, they identified that the specified assessment was meant to be done for a period of time, individual to the resident, and that the goal was to have it filled out each shift. Together, Inspector #679 and the DOC reviewed the assessment charting record. The DOC identified that it was okay that there was missing documentation and that staff would collect the data that was available. [s. 6. (9) 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 ensuring that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Two CI reports were submitted to the Director for incidents of resident to resident abuse. The CI reports identified that resident #002 performed an action towards residents #003 and #004, resulting in injury. The CI report further identified under the section "actions taken to prevent recurrence" that a specific type of care was initiated for resident #002.

In an interview with PCA #111, they identified that resident #002 exhibited responsive behaviours, and that the resident was currently receiving a specific type of care, at specified intervals. PCA #111 identified that the home did not have the staff to assist with

the specified care.

In an interview with Scheduling Clerk #115, they identified that the staffing shortages would be documented on the front of the staffing sheets, or beside the shift on the staffing sheets.

Inspector #679 reviewed the staffing sheets for a 15 day period, and noted that the home was short a staff member to provide the specified care on 13 dates.

In an interview with RPN #104, they identified that the home had initiated a specified type of care for resident #002 after an incident of responsive behaviours. RPN #104 identified that the specified care was to occur at specified intervals, but that the home only had the staff to perform the care a specified number of times per week.

In an interview with RN #110, they identified that resident #002 did not have a staff member to assist with the specified care on a specified date, as the home did not have the staff.

In an interview with Behavioural Supports Ontario (BSO) RPN #108, they identified that resident #002 responsive behaviours, and that they had a specified type of care which was to occur at specified intervals. BSO RPN #108 identified that there was not always staff to assist with the specified care.

In an interview with the DOC, they identified that resident #002 was to receive specific care at specified intervals. The DOC identified that the home did not have the staffing available to assist with the care at specified times, as the home was short PSWs. [s. 8. (1) (b)]

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 ensuring that there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

Issued on this 26th day of February, 2019

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

Original report signed by the inspector.