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
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_0001
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jan 10, 11, 12, 20, 27, 30, 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.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviour, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents and that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The plan is to be submitted in writing to Long Term Care Homes Inspector Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by February 10, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record of an identified resident. Inspector noted the resident had been witnessed by a staff member as having an altercation with a resident putting that resident at risk of harm. No interventions were developed and implemented following this incident. Inspector reviewed a critical incident which identifies this resident as having an altercation with a different resident causing harm to this second resident. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours. [O.Reg. 79/10, s.55(a)] (188)
2. Inspector reviewed the health care record of a resident. Progress notes identify that this resident has a history of responsive behaviours. Inspector noted this resident was witnessed by staff to have an altercation with a resident. Inspector noted that this was not documented anywhere until several days later as a late entry. Inspector noted that this resident's behaviour was not included on the shift report for the days following the incident identifying the resident as requiring heightened monitoring due to the recent behaviour. Inspector spoke with the staff member who witnessed the incident and confirmed to the inspector the events documented in the progress notes. The licensee failed to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. [O.Reg. 79/10, s.55(b)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 02, 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 Director

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
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.

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 30th day of January, 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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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
Jan 10, 11, 12, 20, 27, 30, 2012	2012_099188_0001	Complaint

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing Staff, Personal Support Workers, residents and families.

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

Critical Incident Reports were also reviewed as part of this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Pain

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 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Progress notes identify that this resident has a history of responsive behaviours. Inspector noted this resident was witnessed by staff to have an altercation with a resident. Inspector noted that this was not documented anywhere until several days later as a late entry. Inspector noted that this resident's behaviour was not included on the shift report for the days following the incident identifying the resident as requiring heightened monitoring due to the recent behaviour. Inspector spoke with the staff member who witnessed the incident and confirmed to the inspector the events documented in the progress notes. The licensee failed to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. [O.Reg. 79/10, s.55(b)]
2. Inspector reviewed the health care record of an identified resident. Inspector noted the resident had been witnessed by a staff member as having an altercation with a resident putting that resident at risk of harm. No interventions were developed and implemented following this incident. Inspector reviewed a critical incident which identifies this resident as having an altercation with a different resident causing harm to this second resident. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours. [O.Reg. 79/10, s.55(a)]

Additional Required Actions:

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

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted a progress note entry identifying the resident's preference by the resident's substitute decision-maker (SDM). Inspector reviewed the plan of care for this resident and noted this preference is not identified. Inspector noted a progress note identifying an occasion when this preference was not followed. The licensee failed to ensure that the SDM was given an opportunity to fully participate in the development and implementation of the plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]
2. Inspector reviewed the health care record of a resident. Inspector noted that a progress note entry identifying the substitute decision-makers request related to medication administration. Inspector reviewed the December 2011 medication administration record (MAR) for this resident. Inspector noted that this request related to medication administration was not followed. The licensee failed to ensure that the SDM was given an opportunity to fully participate in the development and implementation of the plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]

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 substitute decision-makers are given an opportunity to fully participate in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted the resident received a drug. Inspector reviewed the physician's orders for this resident and noted no physician's order for this drug. The licensee failed to ensure no drug is administered to a resident in the home unless that drug has been prescribed for the resident. [O.Reg. 79/10, s.131(1)]
2. Inspector reviewed the health care record of a resident. Inspector noted the resident received a drug. Inspector reviewed the physician's orders for this resident and noted no physician's order for this drug. The licensee failed to ensure no drug is administered to a resident in the home unless that drug has been prescribed for the resident. [O.Reg. 79/10, s.131(1)]
3. Inspector reviewed the health care record of a resident. Inspector noted the resident received a drug. Inspector reviewed the physician's orders for this resident and noted no physician's order for this drug. The licensee failed to ensure no drug is administered to a resident in the home unless that drug has been prescribed for the resident. [O.Reg. 79/10, s.131(1)]
4. Inspector reviewed the health care record for a resident. Inspector noted a physician's order for a resident to receive two tabs of a drug. Inspector noted that the medication administration record (MAR) identified that this resident was only administered one tab nine dates instead of the prescribed two tabs. Inspector spoke with a RPN who identified that some staff were only administering one tab and was uncertain as to why this was occurring. Inspector also spoke with a RN who confirmed to the inspector that the MAR did reflect that the resident had only received one tab and was unable to provide an explanation for this. No documentation was located to identify why the physician's order was not followed. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [O.Reg. 79/10, s.131(2)]

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 an identified resident, and all residents' of the home, are administered drugs prescribed for them, in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector reviewed progress notes and the plan of care which indicate this resident has several responsive behaviours. Inspector noted that this resident has not been referred to any specialized resources. Inspector spoke with a RPN who initially reported that the resident had been seen by the psycho-geriatric resource consultant, but later reported that the resident had not been seen. Inspector was unable to locate any evidence that the resident has been referred to, or seen by any outside resources. A RPN and RN also reviewed the resident's health care record and confirmed that the resident has not been referred to or seen by any outside resources. The licensee failed to ensure the resident exhibiting responsive behaviours has been referred to specialized resources. [O.Reg. 79/10, s.53(1)(4)]
2. Inspector reviewed the health care record of a resident. Inspector reviewed progress notes which indicate this resident exhibits responsive behaviours. Inspector reviewed the plan of care for this resident and noted no identification of this responsive behaviour. Inspector noted that no interventions have been developed to respond to the resident's behaviour. The licensee failed to ensure that strategies are developed and implemented to respond to this behaviour. [O.Reg. 79/10, s.53(4)(b)
3. Inspector reviewed the health care record of a resident. Inspector reviewed progress notes which indicates resident had a responsive behaviour. Inspector reviewed the plan of care for this resident and noted no identification of this responsive behaviours. Inspector noted that no interventions have been developed to respond to the resident's responsive behaviour. The licensee failed to ensure that strategies are developed and implemented to respond to this behaviour. [O.Reg. 79/10, s.53(4)(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 residents exhibiting responsive behaviours are referred to specialized resources and strategies are developed and implemented to deal with these behaviours, to be implemented voluntarily.

Issued on this 15th day of February, 2012

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