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 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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 28, 2016 | 2016_273638_0019 | 022674-16, 022779-16, 025496-16, 030396-16 | 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. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

### 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 Complaint inspection.**

**This inspection was conducted on the following date(s): October 12-14, 17-21 and 24-25, 2016.**

**This inspection was related to four complaints. Two complaints regarded insufficient staffing within the home resulting in improper treatment related to dining practices, continence care and fall management. One complaint regarded allegations of staff to resident abuse and concerns related to insufficient staffing causing gaps in resident care, as well as one complaint, regarding infection prevention and control practices, skin and wound, insufficient staffing, fall management, continence care and plan of care concerns.**

**A Follow-Up inspection, was conducted concurrently with this inspection. For additional areas of non compliance, please refer to inspection #2016_273638_0020.**

**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), Personal Support Workers (PSWs), 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 personnel files, licensee policies, procedures and programs and relevant health care records.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**
**Sufficient Staffing**

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

**4 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 2007, c. 8, s. 6 (4).**
**(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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others who were involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complement each other.

A complaint was submitted to the Director in October 2016, which indicated that resident #002 had been hospitalized due to health complications in March 2016.

The Inspector reviewed resident #002's health care record, which indicated that the physician had ordered a series of lab tests in March 2016, to be completed on the next laboratory service date. In a concurrent review of the progress notes for resident #002, RN #117 documented that the tests ordered in March 2016, had not been transcribed into the lab book once the order was received and therefore the ordered tests had not been completed for two weeks. Further review of resident #002's records indicated that the resident was hospitalized two days later.

In an interview with the Inspector, RN #116 stated that when lab work was ordered, it was the role of the registered staff on that shift to transcribe the information into the lab book to notify the laboratory on their testing days which occurred on Mondays and Thursdays of each week.

In a review of the home's policy titled, "Laboratory Services" last reviewed September 14, 2016, it was determined that registered staff were expected to process the physician's orders for specimen collection, including phlebotomy, by completing the appropriate requisition.

The Inspector conducted review of resident #002's health care records with the DOC. The DOC stated that there was no documentation indicating that the orders had been transcribed into the lab book when the order was received in March 2016. During the same interview, the DOC stated that it was the home's expectation that all physician orders were transcribed into the lab book so that the residents would have received their care needs met as ordered. It was expected that the orders for resident #002 were transcribed into the lab book so that the tests would have been completed in a timely manner. [s. 6. (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 to ensure that the staff and others who are involved in the different aspects of care of resident #002 will 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, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A complaint was submitted to the Director, which indicated that resident #002 had been placed on isolation in January 2016, and that the resident was found in the dining room attending meal service by their family while on isolation. The RN allegedly directed front line staff to ensure that the resident was brought to the dining room or they would not receive their meal. Registered staff told the family that the resident was expected to be in the dining room for meals even while on isolation or their meals would not be provided to the resident.

The Inspector conducted a review of resident #002's progress notes, which indicated that the resident had been placed on isolation in January 2016, after exhibiting a trend of symptoms. During this time the resident was brought to the dining room to attend their meal service.

In an interview with the Inspector, RPN #103 stated that any resident who was newly isolated would be required to remain in their room and staff would be required to follow the home's isolation process, which included meal services being provided to the resident in their room. RPN #103 stated that residents were required to be symptom free for 48 hours prior to discontinuing isolation.

The home’s policy titled, “Initiating Isolation” last reviewed July 21, 2016, stated that the required precautions for a resident who was isolated included; the resident being isolated to their room in order to maintain a two meter spatial separation between the infected resident and other individuals.

In an interview with the Inspector, the DOC stated that it was the home’s expectation that any resident who was isolated for contact precautions would have been isolated in their room until being symptom free for a minimum of 48 hours. The DOC stated that during periods of isolation the resident would have been served their meals in their rooms to ensure the spatial separation between the infected resident and other individuals. [s. 229. (4)]

***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 that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

---

**WN #3: 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. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff who was on duty and present at all times.

Two complaints were submitted to the Director, which stated that the home had worked with no RN in the building during various shifts.

The Inspector conducted a review of the home's RN schedule between April 2016 and October 2016, which indicated that the home worked with no RN in the building on four identified dates in June, July and August 2016.

In an interview with the Inspector, the DOC stated that during the shifts identified, the home did work with no RN in the building and had a RPN in the role of "RPN Supervisor" performing the duties of the RN. The DOC stated that during these dates a RN was on call, however, upon reviewing the legislative requirements, the DOC stated that they were not eligible to conduct in this manner. [s. 8. (3)]

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who were expected to provide the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

Two complaints were submitted to the Director, which stated that the home had worked with no RN in the building during various shifts.

The Inspector conducted a review of the home's RN schedule between April 2016 and October 2016, which indicated that the home worked with no RN in the building on four identified dates in June, July and August 2016.

A review of the home's policy titled, "Process for Staff Replacement" last reviewed October 20, 2016, indicated that when the home was required to replace a RN shift and all attempts to replace the staff member with another RN had failed, the home would call in an extra RPN to assume the role of "RPN Supervisor" with an RN accessible by telephone.

The Inspector reviewed the legislative requirements laid out under s. 8 (3) within the Long-Term Care Homes Act, 2007 (LTCHA) as well as the 24 hour RN exceptions under s. 45 (1) 2. ii. within the Ontario Regulation 79/10 (O.Reg), which indicated that the home was not a candidate to utilize an RPN acting in the role of an RN during any circumstance.

The Inspector conducted a review of the LTCHA and O.Reg with the DOC. In an interview the DOC stated that the backup plan for replacing an RN did not meet the legislative requirements laid out within the LTCHA and O.Reg. [s. 31. (3) (d)]

**Issued on this 29th day of December, 2016**

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

**Original report signed by the inspector.**