

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

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

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

**Division des opérations relatives aux
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
May 4, 2021	2021_828744_0006	002499-21, 003589- 21, 003626-21	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. Joseph's Villa, Sudbury
1250 South Bay Road Sudbury ON P3E 6L9

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

STEVEN NACCARATO (744)

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): March 22-26,29, 2021.

The following intakes were inspected upon in this Critical Incident System (CIS) inspection:

- One intake related to a missing or unaccounted for controlled substance;**
- One intake related to a resident to resident altercation; and**
- One intake related to a fall that resulted in injury to the resident and transfer to hospital.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA), Housekeepers, caregivers and residents.

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

The following Inspection Protocols were used during this inspection:

- Falls Prevention**
- Infection Prevention and Control**
- Medication**
- Responsive Behaviours**

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
 - (i) that is used exclusively for drugs and drug-related supplies,**
 - (ii) that is secure and locked,**
 - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
 - (iv) that complies with manufacturer's instructions for the storage of the drugs;**
- and O. Reg. 79/10, s. 129 (1).**
- (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

A Critical Incident System (CIS) report was submitted to the Director, which indicated there was a missing controlled substance.

A Registered Nurse (RN) indicated that they had inappropriately disposed of a controlled substance, which they had discovered was misplaced in the medication room. The RN further indicated that they should have double locked the misplaced controlled substance upon its discovery.

Sources: "The Medication Storage" policy revised January 2018; Internal investigation notes; and interviews with the RN and other staff members. [s. 129. (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 to ensure that controlled substances are stored in a separate locked area within the locked medication cart, 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 staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically relating to the use of IPAC signage.

The home's policy titled "Initiating Isolation and Additional Precautions", dated January 2004, indicated that a notice was to be placed on the resident/patient's door to indicate the type of precautions to be taken. Inspector #744 observed six resident rooms which had a yellow personal protection caddy on their door; however, the Inspector was unable to locate signage on the resident doors to identify the type of additional precautions required.

In an interview with a RN, they indicated that signage identifying the type of additional precautions required for a resident, must be located on the door of the residents' room. The RN confirmed that the six residents required signage for additional precautions; however, they were unable to locate the signage on the residents' door.

Sources: Inspector observations on March 26 and 29, 2021; "Initiating Isolation and Additional Precautions" policy dated January 2018; "Additional Precautions Tracker: ARO's"; and interviews with the RN and other staff members. [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 (IPAC) program, to be implemented voluntarily.

Issued on this 6th day of May, 2021

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

Original report signed by the inspector.