Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: February 8, 2024	
Inspection Number: 2024-1397-0002	
Inspection Type: Complaint	
Licensee: St. Joseph's Health Centre of Sudbury	
Long Term Care Home and City: St. Joseph's Villa, Sudbury, Sudbury	
Lead Inspector Sylvie Byrnes (627)	**Inspector Digital Signature** Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2024.02.14 09:47:06 -05'00'
Additional Inspector(s) Loviriza Caluza (687) Shelley Murphy (684)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 18-19, and 22-26, 2024.

The following intake(s) were inspected:

- One complaint regarding improper/incompetent care of a resident; and,
- One complaint of a resident's fall that resulted in death.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that every alleged incident of abuse toward a resident was immediately investigated.

Rationale and Summary

A family member brought forth concerns of resident abuse to a registered staff member. The staff member reported the allegations of abuse to the Director of Care (DOC) who did not investigate the incident as they felt the issue had been resolved by the registered staff member.

There was no harm to the resident when allegations of abuse were not investigated.

Sources: Interviews with a resident's family member, a Registered Nurse, and DOC; record review of email, interview notes and the home's policy titled, "Zero Tolerance

For Abuse and Neglect". [627]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary

A resident was sent to the hospital for an injury they sustained in the home. The resident required a changes to their plan of care when they returned to the home. The Director was not made aware of the resident's injury. The DOC stated that they had not reported the incident as they had not recognized it as a significant change since the resident's physical needs had remained unchanged.

There was low risk to the resident when an incident that caused an injury was not reported to the Director. **Sources:** Interview with DOC; Physician's order, hospital diagnostic test

results, email correspondence and the home's policy titled, "Critical Incident Reporting and Review". [627]