

**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**

<b>Report Issue Date:</b> July 10, 2024	
<b>Inspection Number:</b> 2024-1397-0004	
<b>Inspection Type:</b> Complaint Critical Incident	
<b>Licensee:</b> St. Joseph's Health Centre of Sudbury	
<b>Long Term Care Home and City:</b> St. Joseph's Villa, Sudbury, Sudbury	
<b>Lead Inspector</b> Shelley Murphy (684)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Jennifer Nicholls (691)	

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): June 24 to 28, 2024

The following intake(s) were inspected:

- One Intake related to physical abuse of resident by a staff member;
- One intake related to an outbreak;
- Three Intakes related to resident to resident physical abuse; and,
- One Complaint Intake related resident rights.

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

Infection Prevention and Control

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Prevention of Abuse and Neglect  
Responsive Behaviours  
Residents' Rights and Choices  
Reporting and Complaints

## 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. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.

The Ontario Regulations (O. Reg.) 242/22, s. 7., defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

#### **Rationale and Summary**

A Critical Incident (CI) report was received by the Ministry of Long-Term Care (MLTC) about an alleged incident of a physical abuse involving a staff member and a resident.

A review of the investigation notes indicated that a staff member stated that they

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witnessed another staff member abuse the resident.

The Director of Care (DOC) verified that the action towards the resident by the staff member resulted in abuse to the resident.

This resulted in minimal harm to the resident as they did not sustain physical injury.

**Sources:** CIS report, Review of the home's "Zero Tolerance for abuse and neglect"; investigation notes; review of the resident's electronic health records including progress notes; Point Of Care (POC) documentation; head to toe assessments; and interviews with the DOC, and other staff.

[691]

## **WRITTEN NOTIFICATION: Reporting and Complaints**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 26 (1) (c)**

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure that they immediately forwarded to the Director any written complaint it received concerning the care of a resident and the operation of the long-term care home in the manner set out in the regulations.

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**Rationale and Summary**

During the pre-inspection interview with the complainant, they indicated that they submitted a email complaint to the home regarding concerns they had about resident rights.

The Director of Care (DOC) stated that the complaint that was submitted to the home regarding resident rights did not get submitted to the Ministry of Long-term Care (MLTC).

The risk to residents is low and not submitting the complaint did not put any residents at risk.

**Sources:**

Complainant and DOC interview, Home's policy titled "Complaints, Concerns and Suggestions Process", last reviewed April 22, 2024.

[684]

**WRITTEN NOTIFICATION: Reporting Certain Matters to the Director**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 28 (1)**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff

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that resulted in harm or a risk of harm to the resident.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that the allegation of staff to resident abuse, involving a resident was immediately reported to the Director.

**Rationale and Summary**

On a specified day, it was alleged that a staff member witnessed another staff member become abusive with a resident while providing care to the resident. This was reported to another staff member on that same day, however the incident did not get reported to the Director until the next day.

In an interview with the Director of Care (DOC), they indicated that they were notified of the allegation of staff to resident abuse via email by the second staff member the day after the incident occurred, and the staff should have been immediately reported to the Director, using the After-Hours line.

There was minimal risk of harm by the allegation of staff to resident abuse not being immediately reported to the Director.

**Sources:** CI report; internal investigation notes; licensee policy titled "Zero Tolerance for Resident Abuse and Neglect"; interview with DOC, and other staff.

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**WRITTEN NOTIFICATION: Responsive Behaviours**

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(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.

The licensee has failed to ensure that an assessment was completed and analyzed for a resident's responsive behaviours.

**Rationale and Summary**

An assessment was initiated for a resident on two separate occasions, for a number of days after the resident was exhibiting responsive behaviours towards other residents. A review of the document showed missing information for multiple days, and after the observation periods, the analysis of the observation findings was not completed.

The DOC acknowledged that the monitoring was not completed as required.

Failure to document and complete the analysis placed the resident at risk for not receiving appropriate care as a result of unidentified behavioural triggers.

Sources: The resident's clinical records; and an interview with the DOC, and other staff.

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**WRITTEN NOTIFICATION: Dealing with Complaints**

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NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 108 (2)**

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

- (a) the nature of each verbal or written complaint;
- (b) the date the complaint was received;
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (d) the final resolution, if any;
- (e) every date on which any response was provided to the complainant and a description of the response; and
- (f) any response made in turn by the complainant.

The licensee failed ensure that there was a documented record for all received complaints.

**Rationale and Summary**

The DOC was unable to provide the Inspector with a log of complaints received in 2023 and to date in 2024.

The home's policy stated "The Administrator or delegate will maintain a log of all verbal complaints not resolved within 24 hours and all written complaints received regardless of the amount of time recorded to resolve."

The lack of documentation for the home's complaint process is low risk with no impact to the residents.

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Sources: Director of Care Interview, the home's policy "Concerns, Complaints and Suggestions Process, last reviewed April 22, 2024.

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