



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

**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**

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**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Aug 29, 2013	2013_104196_0013	S-001039- 12,S-000679 -12	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**

**LAUREN TENHUNEN (196)**

**Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): June 10, 11, 12, 13, 14, 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Vice President Clinical Services, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Human Resources, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family members**

**During the course of the inspection, the inspector(s) conducted a tour of all resident home areas, observed the provision of care to residents, observed the interactions between staff members and residents, reviewed the health care records for several residents, reviewed various home policies and procedures**

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

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<b>Legend</b>	<b>Legendé</b>
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

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**Findings/Faits saillants :**



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1. In February 2012, the management became aware of allegations of abuse towards three residents by a staff member of the home. An interview with management staff member #100 was conducted in June 2013 and it was determined that the information regarding the allegations of abuse towards residents was not reported to the Director. The Critical Incident System was reviewed and a mandatory report had not been received.

The licensee failed to ensure that 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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

***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 that ensures that 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; abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.***



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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**

**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**

- (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
- (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
- (c) identifies measures and strategies to prevent abuse and neglect;**
- (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
- (e) identifies the training and retraining requirements for all staff, including,
  - (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
  - (ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.****

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**Findings/Faits saillants :**



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1. The licensee's policy titled "Zero Tolerance for Abuse and Neglect" with the last revision date of February 7, 2012 was reviewed by the inspector. The policy did not include any procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The licensee failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; [s. 96. (a)]

2. The licensee's written policy titled "Zero tolerance for Abuse and Neglect" with a revision date of February 7, 2012 was reviewed by the inspector. The policy did not include measures or strategies aimed at preventing abuse and neglect of residents.

The licensee failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (c) identifies measures and strategies to prevent abuse and neglect; [s. 96. (c)]

***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 that ensures the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and identifies measures and strategies to prevent abuse and neglect, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**



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

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**

**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**

**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

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**Findings/Faits saillants :**

1. In February 2012, the management became aware of allegations of abuse towards three residents by a staff member of the home. An interview was conducted with management staff member #100 in June 2013. It was reported to the inspector, that the investigation was undertaken and it had supported the allegations of mental and verbal abuse towards residents and that the substitute decision makers (SDM) of these particular residents were not informed of the allegations or investigation of abuse.

The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being [s. 97. (1) (a)]



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**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 that will ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director**

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

**s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).**

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**Findings/Faits saillants :**

1. The management received written complaints in February 2012 regarding a matter that the licensee must report to the Director under section 24 of the Act, specifically, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. A copy of the written complaints and a written report documenting the licensee's response to the complainant were not forwarded to the Director.

The licensee of a long-term care home received a written complaint with respect to a matter that the licensee is required to report to the Director under section 24 of the Act, and failed to submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101(1). [s. 103. (1)]





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***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 that will ensure that the licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, submits a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101(1)., to be implemented voluntarily.***

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Issued on this 4th day of September, 2013

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

*Lauren Lenhunen #196.*