Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANA STENLUND (163), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2013_139163_0030
Log No. / Registre no:	S-000402-13,407-13,415/416-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 18, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST. JOSEPH'S VILLA, SUDBURY 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNE PALKOVITS

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that all nursing staff comply with the home's policy, "Falls Prevention and Management Program" and the nursing training document titled "Clinical Assessment After a Fall", specifically related to the actions to be taken by nursing staff after a resident has fallen.

Grounds / Motifs :

1. Inspectors reviewed the home's policy titled "Falls Prevention and Management Program". This document outlines that when a resident has fallen, staff must not move the resident if there is suspicion or evidence of injury. The policy adds that it is preferable to immobilize the resident where they are found and allow EMS to transport the resident as necessary.
Inspectors reviewed a training document which is also part of the home's falls prevention and management program, titled "Clinical Assessment After a Fall". This training document informs staff of the following actions to be taken after a resident has fallen:
Before moving a resident, rule out fracture or dislocation, if either is suspected or if unable to rule out, do not move resident as moving a resident could result in spinal cord damage, further displacement, increased pain.
This document also identifies the possible signs of a fracture including, tenderness at site of fracture, visible deformity, extremity appears shortened, and inability to move affected limb/joint. The inspectors interviewed the Assistant Director of Care (ADOC) who reported that this training document is presented

to nursing staff as part of their falls prevention and management training.

Inspectors reviewed resident's #515 Critical Incident (CI) report and health care record regarding a fall that resulted in injury and transfer to hospital. Resident #515 was diagnosed in hospital with a fracture. Nursing documentation after the fall outlines that nursing staff found resident #515 on the found on the floor and that the resident sustained injury and were unable to move their injured limb. Documentation in the progress notes identifies that shortly after the fall, resident #515 was lying in bed and was assessed by the RN. Inspectors interviewed the ADOC about the events which occurred after the fall until when the resident was later assessed in bed by registered nursing staff. The ADOC confirmed that, according to the documentation, it is difficult to clearly identify the actions taken by staff, however, the ADOC reported that the resident was assessed in bed, confirming that the resident had been transferred by staff from the floor to the bed despite evidence of injury to the resident.

Inspectors reviewed the documentation contained in a CI report related to resident #415 who fell, sustained a fracture, and subsequently passed away. CI notes, progress notes, and nursing staff interviews relating to the fall, indicated that resident #415 would cry and/or scream in response to movement of their injured limb. Inspectors reviewed video feed of the fall involving resident #415 and noted that after the fall, the resident was transferred by staff from the floor into a wheelchair using a mechanical lift.

The actions of nursing staff are not in compliance with the home's policy titled "Falls Prevention and Management Program" or with the training document titled "Clinical Assessment After a Fall". The licensee has not ensured that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 24, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.221(1)1. The plan shall be submitted to Diana Stenlund, MOHLTC Inspector by Nov 29/13.

For the purposes of paragraph 6 of subsection 76(7) of the Act, the licensee shall ensure that training on Falls Prevention and Management is provided to all staff who provide direct care to residents. The training shall occur at times or intervals provided for in the regulations.

Grounds / Motifs :

1. Inspectors reviewed the training attendance records for 2012 and for 2013, up to October 30, 2013, regarding falls prevention and management. Records indicate that approximately 50% of nursing staff personnel did not receive their required training in 2012.
In addition, inspectors noted through review of the health care records and video feed footage, two registered nursing staff members (#100 and #200) were involved in assessing resident #415 who sustained injury, and subsequently passed away. It was also identified by the inspectors that resident #415 was transferred from the floor into a wheelchair despite evidence of injury. This is contrary to the direction outlined in the home's falls prevention and management training document titled "Clinical Assessment After a Fall" and the home's policy titled "Falls Prevention and Management Program". Inspectors also noted that staff members #100 and #200 did not receive their required training on falls prevention and management in 2012, or in the current year up to the inspection date of Oct 30, 2013.
Furthermore, inspectors also identified that staff #100 was involved with assessing resident #515 who sustained injury as a result of a fall. It was identified by the inspectors through review of the health care records and staff interviews, that resident #515 was transferred from the floor into bed contrary to the home's training and policy on falls prevention and management. The licensee has not ensured that training on Falls Prevention and Management is provided to all staff who provide direct care to residents.
For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee has not ensured that training has been provided to all staff who provide direct care to residents, specifically related to Falls Prevention and Management. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 24, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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

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

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2013	2013_139163_0030	S-000402-13,407-13,415/416-13	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

DIANA STENLUND (163), JENNIFER LAURICELLA (542)

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 28-30, 2013

During the course of the inspection, the inspector(s) spoke with Vice President of Clinical Services, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager, Food Services Manager, dietary staff, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) and residents.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident care and interactions, reviewed home policies and procedures relating to the home's staffing plan and the falls prevention and management program.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Falls Prevention

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspectors reviewed the home's policy titled "Falls Prevention and Management Program". This document outlines that when a resident has fallen, staff must not move the resident if there is suspicion or evidence of injury. The policy adds that it is preferable to immobilize the resident where they are found and allow EMS to transport the resident as necessary.
Inspectors reviewed a training document which is also part of the home's falls prevention and management program, titled "Clinical Assessment After a Fall". This training document informs staff of the following actions to be taken after a resident has fallen:
Before moving a resident, rule out fracture or dislocation, if either is suspected or if unable to rule out, do not move resident as moving a resident could result in spinal cord damage, further displacement, increased pain.
This document also identifies the possible signs of a fracture including, tenderness at site of fracture, visible deformity, extremity appears shortened, and inability to move affected limb/joint. The inspectors interviewed the Assistant Director of Care (ADOC) who reported that this training document is presented to nursing staff as part of their falls prevention and management training.

Inspectors reviewed resident's #515 Critical Incident (CI) report and health care record regarding a fall that resulted in injury and transfer to hospital. Resident #515 was diagnosed in hospital with a fracture. Nursing documentation after the fall outlines that nursing staff found resident #515 on the floor and that the resident sustained injury and were unable to move their injured limb. Documentation in the progress notes identifies that shortly after the fall, resident #515 was lying in bed and was assessed by the RN. Inspectors interviewed the ADOC about the events which occurred after the fall until when the resident was later assessed in bed by registered nursing staff. The ADOC confirmed that, according to the documentation, it is difficult to clearly identify the actions taken by staff, however, the ADOC reported that the resident was assessed in bed, confirming that the resident had been transferred by staff from the floor to the bed despite evidence of injury to the resident.

Inspectors reviewed the documentation contained in a CI report related to resident #415 who fell, sustained a fracture, and subsequently passed away. CI notes, progress notes, and nursing staff interviews relating to the fall, indicated that resident #415 would cry and/or scream in response to movement of their injured limb. Inspectors reviewed video feed of the fall involving resident #415 and noted that after the fall, the resident was transferred by staff from the floor into a wheelchair using a

mechanical lift.

The actions of nursing staff are not in compliance with the home's policy titled "Falls Prevention and Management Program" or with the training document titled "Clinical Assessment After a Fall". The licensee has not ensured that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Inspectors reviewed the training attendance records for 2012, and for 2013 up to October 30, 2013, regarding falls prevention and management. Records indicate that approximately 50% of nursing staff personnel did not receive their required training in 2012.
In addition, inspectors noted through review of the health care records and video feed footage, two registered nursing staff members (#100 and #200) were involved in assessing resident #415 who sustained injury, and subsequently passed away. It was also identified by the inspectors that resident #415 was transferred by staff from the floor into a wheelchair despite evidence of injury to the resident. This is contrary to the direction outlined in the home's falls prevention and management training document titled "Clinical Assessment After a Fall" and the home's policy titled "Falls Prevention and Management Program". Inspectors also noted that staff members #100 and #200 did not receive their required training on falls prevention and management in 2012 or in the current year up to the inspection date of October 30, 2013.
Furthermore, inspectors also identified that staff #100 was involved with assessing resident #515 who sustained injury as a result of a fall. It was identified by the inspectors through review of the health care records and staff interviews, that resident #515 was transferred by staff from the floor into bed contrary to the home's training and policy on falls prevention and management. The licensee has not ensured that training on Falls Prevention and Management is provided to all staff who provide direct care to residents.
For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee has not ensured that training has been provided to all staff who provide direct care to residents, specifically related to Falls Prevention and Management. [s. 221. (1) 1.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Inspectors reviewed the health care record including progress notes and CI report for resident #415 relating to an unwitnessed fall, where the resident sustained a fracture and subsequently passed away. The documents reviewed outlined that resident #415 was found on the floor by nursing staff and was noted to cry and/or scream in response to movement of their injured limb. Inspectors reviewed the video feed of the fall incident. It indicated that the resident was transferred by staff from the floor to a wheelchair using a mechanical lift. The Emergency Medical Services (EMS) report also confirmed that the resident was sitting in a wheelchair when they arrived. Inspectors reviewed the home's documentation of the interventions taken after the fall had occurred. Records do not contain documentation that resident #415 was transferred by staff from the floor to a wheelchair using a mechanical lift.

Inspectors reviewed a CI report where resident #515 had fallen, sustained a fracture and was transferred to hospital. The CI identifies that the resident was found on the floor and was injured. The health care record indicates that resident #515 also complained of pain when their injured limb was moved and that resident #515 was further assessed in bed by registered nursing staff. Inspectors reviewed the health care record regarding this fall incident and were unable to identify in the documentation, any actions or interventions taken by staff regarding transferring the resident into bed. Inspectors interviewed the ADOC who confirmed that documentation pertaining to this incident does not clearly indicate the actions taken by staff to transfer the resident from the floor to the bed.
The licensee has not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [s. 30. (2)]

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 any actions taken with respect to a resident who has fallen, that the actions, including assessment, reassessment, interventions and the resident's responses to the interventions are documented, to be implemented voluntarily.

Issued on this 19th day of November, 2013

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

Diana Stenlund, #163