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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014	2014_332575_0014	S-000359-14	Resident Quality Inspection

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.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

LINDSAY DYRDA (575), KELLY-JEAN SCHIENBEIN (158), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 18-22 and 25-29, 2014

A follow-up log, 4 critical incident (CI) log(s), and 2 complaint logs were also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Site Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW), Recreation Workers, Environmental Services Manager, Food Services Manager, Dietary Aides, Housekeeping Staff, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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During the course of this inspection, Non-Compliances were issued.

9 WN(s)
3 VPC(s)
2 **1 CO(s)**
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2013_211106_0020	575

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

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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for the Falls Prevention and Management Program. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered on the following dates: December 2, 2013 and January 9, 10, 2014. The records indicated that

in 2013 only 5/126 direct care staff completed the training and in 2014 only 20/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 67/126 direct care staff had completed the training and in 2014 only 58/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for falls prevention and management in November 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in falls prevention and management. [s. 221. (1) 1.]

2. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for the Skin and Wound Care Program. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered on the following dates: July 18, 2013 and April 17, 22, 23, 2014. The records indicated that in 2013 only 3/126 direct care staff completed the training and in 2014 only 14/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 83/126 direct care staff had completed the training and in 2014 only 52/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for skin and wound care in December 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in skin and wound care. [s. 221. (1) 2.]

3. Inspector #543 requested staff training records for direct care staff (RN, RPN, PSW) for Continence Care and Bowel Management. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered on the following dates: August 12, 2013 and May 5, 6, 2014. The records indicated that in 2013 only 9/126 direct care staff completed the training and in 2014 only 16/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 63/126 direct care staff had completed the training and in 2014 only 68/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for continence care in October 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the

numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in continence care and bowel management. [s. 221. (1) 3.]

4. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for Responsive Behaviours. The inspector reviewed the 2013 and 2014 education records for the home and noted that training was offered on the following dates: October 23, 2013 and February 5, 11, 20, 21, 2014. The records indicated that in 2013 only 13/126 direct care staff completed the training and in 2014 only 21/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 101/126 direct care staff had completed the training and in 2014 only 89/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for responsive behaviours in November 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff receive the required training annually, specifically regarding behaviour management. [s. 221. (2),s. 221. (2) 1.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspector #158 reviewed resident #2824's health care record. A quarterly assessment completed identified that the resident required extensive physical assistance for personal hygiene, which included oral care. On August 20, 2014 resident #2824 stated to the inspector that the staff do not always provide oral care and that they (the resident) have a hard time to perform oral care on their own. The inspector reviewed resident #2824's care plan and noted that it did not clearly identify the assistance resident #2824 requires in the provision of their oral care.
The licensee has failed to ensure that resident #2824's written plan of care provides clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On August 28, 2014 inspector #543 and #575 reviewed resident #001's health care record. The resident had a fall for which the resident was transferred to hospital, and shortly after the home was notified of the resident's death. Inspector #543 spoke with the Site Administrator about resident #001, regarding concerns of the resident's care plan not identifying that the resident was high risk for falls. The Site Administrator confirmed that the care plan did not address that the resident was high risk for falls and did not identify how this resident could call for assistance when not in bed.
The licensee has failed to ensure that the plan of care set out clear directions to staff and

others who provide direct care to the resident. [s. 6. (1) (c)]

3. On August 21, 2014 inspector #575 reviewed resident #2806's health care record. The MDS assessment identified that the resident has had worsening behaviours. During interviews, staff members #100 and #200 told the inspector that the resident is verbally abusive towards staff. The staff members each stated that staff are to provide care when the resident asks in order to prevent behaviours and if the resident displays this behaviour, staff are to leave and come back later to attempt care. The staff members indicated that the resident prefers 'regular' staff and allows these staff to perform more care. The staff members also stated that the resident is able to direct their own care and this is important to maintain their independence. Inspector #575 reviewed the care plan for resident #2806 and determined that the care plan did not indicate the needs and preferences that the staff members had identified.
The licensee did not ensure that the care set out in resident #2806's plan of care was based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

4. Inspector #158 reviewed a CI. The substitute decision maker (SDM) of resident #2900 identified that they were not informed of changes to resident #2900's plan of care. The inspector reviewed the resident's health care record. The Dietitian assessed resident #2900 and identified that the resident was not eating their full breakfast. The Dietitian continued the resident's diet as previously ordered and added nutritional supplements during snacks. Approximately 1 month later, the Dietitian assessed the resident again and as a result the resident's prescribed diet was then changed.
Resident #2900's progress notes were reviewed and documentation identifying that the resident's SDM was informed of the diet change was not found.
The licensee has failed to ensure that the resident #2900's SDM, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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 ensuring that the written plan of care for resident #2824 and any other resident sets out clear directions to staff and others who provide direct care to the resident, that resident #2806's plan of care is based on an accurate assessment of the resident and the resident's needs and preferences, and that resident #2900's SDM is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #3: 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. Inspector #543 reviewed the home's policy titled 'Continence Care Program'. This policy stated that the RN and RPNs roles and responsibilities are to complete a Bowel and Bladder Continence Assessment upon admission, quarterly, and with any change in condition that affects continence.
The inspector reviewed resident #2796's heath care record and identified that this resident was admitted to the home in 2011. The Bladder and Bowel Continence Assessments were reviewed identifying that this resident was assessed 2 times in 2012 and 2 times in 2013. No assessments were identified in Point Click Care (PCC) after the year 2013. Therefore, as per the documentation, this resident was not provided a Bladder and Bowel Continence Assessment on admission, or quarterly. Additionally, the

inspector spoke with a staff member who confirmed that Bowel and Bladder Continence Assessments are to be performed on admission as well as quarterly. The staff member confirmed that these assessments would be documented in PCC under the 'Assessments' tab.
The licensee has failed to ensure that the home's 'Continence Care Program' policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. Inspector #575 reviewed the health care record for resident #2887. The health care record identified that the resident had an fall in 2014. The home's policy titled 'Falls Prevention and Management Program' last revised January 10, 2014 was reviewed. The inspector noted that the home's policy indicated that registered staff are to initiate the 'Head Injury Routine' (HIR) if the resident struck their head or if they had an unwitnessed fall. The inspector noted that the HIR was initiated during the evening shift, however it was discontinued during the next day shif and was not filled out completely. The HIR indicates that vital signs are to be documented every 30 minutes x4, every 1 hour x4, then every shift for 48 hours. Vital signs were only documented once during the evening shift and once during the night shift.
The licensee has failed to ensure that the 'Falls Prevention and Management Program' policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. Inspector #575 reviewed the policy titled 'Wound and Skin Care Program' last revised August 14, 2014. The policy indicated that all residents are assessed for skin breakdown or the potential for skin breakdown using the following assessment tools: RAI MDS, Braden Scale, Head to Toe, Physiotherapy, and Nutritional Risk. According to the policy, the RAI MDS, Head to Toe, Physiotherapy, and Nutritional Risk assessments are to be completed upon admission, quarterly, and with any changes that may affect skin integrity. The inspector reviewed the health care records of resident #2806, #2817, and #2884. Resident #2806's Head to Toe and Nutritional Risk assessments were not completed as specified in the policy. Resident #2806 only had Head to Toe assessments completed 2 times in 2013 (not quarterly), and the most recent Nutritional Risk assessment was overdue for the next quarterly assessment. Resident #2817's Nutritional Risk Assessments were not completed as specified in the policy. Resident #2817 has not had a Nutritional Risk Assessment completed since the beginning of 2014. Resident #2884's Head to Toe and Nutritional Risk assessments were not completed as specified in the policy. Resident #2884 only had Head to Toe assessments completed 2 times in 2013 and only once in 2014 (not quarterly), and the most recent Nutritional Risk assessment is dated in 2013 (overdue for all quarterly assessments in 2014 to date). The licensee has failed to ensure that the 'Wound and

Skin Care Program' policy was complied with. [s. 8. (1) (a),s. 8. (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 ensuring that the home's policies titled 'Continence Care Program', 'Falls Prevention and Management Program', and 'Wound and Skin Care Program' are complied with, to be implemented voluntarily.

WN #4: 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. On August 22, 2014 inspector #158 observed that 2 tubes of Voltaren topical cream were stored in resident #2810's bedside table and that 1 of the tubes' cap was off. The inspector reviewed resident #2810's physician orders on August 24, 2014 and noted that there was a current order to apply the Voltaren topical cream twice per day (BID) as needed however there was no direction for self-use or to leave the cream at the bedside. It was further noted that the direction on one of the tubes was to apply Voltaren topical cream BID was discontinued.
The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

2. On August 22, 2014 inspector #158 observed that a medicated cream was stored in resident #2824's bedside table. The date on the container was December 2013 with the direction that the cream be applied for seven days. The inspector reviewed resident #2824's physician orders and noted that there was no direction to leave at the bedside. Furthermore, there was no current order for the medicated cream.
The licensee did not ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)]

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 ensuring that drugs are stored in an area of a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On August 23 and 24, 2014 inspector #158 observed that the dining room tables in a home area had not been cleaned before the evening meals. The inspector also observed that the floor in this unit was littered with brown food particles. Three family members in this home area identified that the dining room is not always cleaned, which is not acceptable according to them. A review of the Family Council minutes showed that the issue of the uncleaned tables was previously identified.
The licensee did not ensure that the floor in the dining room and its furnishing, specifically dining room tables were clean. [s. 15. (2) (a)]

WN #6: 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).

Findings/Faits saillants :

1. During a resident interview it was identified that resident #2810 had missing money a few months ago. Inspector #543 reviewed this resident's progress notes. The progress notes identified that a student reported to staff member #102 that this resident was missing money. No further documentation was entered into PCC progress notes regarding this matter.
On August 27, 2014 inspector #543 spoke with the DOC regarding missing money from resident #2810. The DOC stated the concern would be forwarded to staff member #501 as the DOC was not made aware of this resident's missing money in when it occurred. Staff member #501 followed up with resident #2810's missing money. The staff member confirmed that they did not receive an internal 'occurrence report' regarding this matter and stated that the last 'occurrence report' received for resident #2810 was from 2011. No internal report was brought forward regarding the missing money.
Inspector #543 reviewed the home's policy 'Reporting and Investigation of Theft or Loss'. This policy stated that thefts or losses are to be reported to the Departmental Manager or designate as soon as possible. Details of all thefts and losses are to be outlined on a 'Theft or Loss Report' form and all thefts and losses will be investigated.
The inspector noted that the resident's missing money was not reported to the Director as required. The licensee has failed to ensure that a person who has reasonable grounds to suspect that misuse or misappropriation of a resident's money has occurred shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Inspector #158 spoke with staff member #103. The staff member stated that they routinely run out of utensils and resort to using plastic cutlery at meal service. Inspector #158 observed that spoons were not available for dessert and plastic spoons were used for all residents on 2 occassions. The inspector reviewed the home's policy 'Meal Service Routine' that identifies that the Cooks and Food Service Workers will ensure that all utensils for the dining room and services will be in each home area at each meal service.
The licensee has failed to ensure that its policy was implemented relating to nutrition care and dietary services 'Meal Service Routine' related to the provision of utensils. [s. 68. (2) (a)]

2. On August 22, 2014 inspector #575 observed that pudding and 2 bananas were on the afternoon nutritional cart in a home area. On August 25 and 26, 2014 inspector #158 observed that resident nutritional supplements such as fortified shakes and puddings were not on the nutritional cart but remained in the home area fridge during the afternoon nutritional pass and at lunch. On August 25, 2014 inspector #158 observed that resident nutritional supplements such as fortified shakes, boost, and resource were not on the nutritional cart but remained in the home area's fridge during the afternoon nutritional pass and at lunch.
Inspector #158 reviewed the health care records of 5 residents in one home area and 3 residents in another home area.
Nutritional supplements including high protein shakes, boost, and resource 2.0 were ordered in their recent Quarterly Medication Reviews.
Inspector #158 reviewed the above 8 resident's health care records which showed that the Dietitian assessed the residents regarding their nutritional risk and that nutritional supplements such as fortified shakes, extra protein, boost, etc., were ordered to manage the residents' nutritional risk.
The licensee did not ensure that the nutritional supplements such as fortified shakes, extra protein, boost, etc., were offered to 8 residents, therefore failed to implement interventions to mitigate and manage risks related to nutrition care, dietary services, and hydration. [s. 68. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. In response to a CI, inspector #543 reviewed the home's records regarding an enteric outbreak in one of the home areas. The inspector identified that the outbreak was declared by Public Health on February 13, 2014. Line listing was done for both staff members and residents who displayed symptoms (ie: vomiting, diarrhea, etc.). This information was forwarded to Public Health on February 24 and 26th, 2014. Public Health declared the outbreak over on February 28, 2014. The home did not inform the Ministry of Health and Long-Term care of the outbreak until March 6, 2014.
Therefore, the licensee failed to immediately inform the Director of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. [s. 107. (1) 5.]

WN #9: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On August 26, 2014 inspector #575 observed staff member #104 administer medication to resident's #2833, #2812, and #2883. The inspector noted that the staff member did not wash their hands before or after administration of any medications or between residents. The inspector reviewed the home's 'Hand Hygiene' policy last revised January 23, 2014. The policy indicated that hand hygiene is required to be followed before initial resident environment contact, before aseptic procedure, after bodily fluid exposure, and after resident environment contact.
The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Inspector #543 reviewed the home's policy 'Tuberculosis'. This policy stated that residents will be screened within one week of admission and annually thereafter. The inspector randomly chose 4 residents from the census sample and identified that none of the residents chosen had been screened for tuberculosis within one week of admission or within the Ministry's required 14 days of admission.
Inspector #543 spoke with DOC regarding tuberculosis screening. The inspector told the DOC that she was unable to locate past history of TB screening for numerous residents. The DOC confirmed that when the home first opened they did not perform TB screening on residents within one week of admission as indicated in their policy or within the Ministry requirements of 14 days of admission.
Therefore, the licensee did not ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

Issued on this 12th day of December, 2014

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

Original report signed by the inspector.

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

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) :	LINDSAY DYRDA (575), KELLY-JEAN SCHIENBEIN (158), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_332575_0014
Log No. / Registre no:	S-000359-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 12, 2014
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.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

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:

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 : 001

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 to ensure that all staff who provide direct care to residents receive annual training in the following:

1.) Falls prevention and management;
2.) Skin and wound care; and
3.) Continence care and bowel management.

This plan is to include but not be limited to the timeframes by which training in each of the above will occur and be completed.

The plan shall be submitted by January 30, 2015 and fully implemented by May 31, 2015.

The plan shall be submitted in writing to Lindsay Dyrda, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, ON, P3E 6A5 or Fax at 705-564-3133.

Grounds / Motifs :

1. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for the Falls Prevention and Management Program. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered on the following dates: December 2, 2013 and January 9, 10, 2014. The records indicated that in 2013 only 5/126 direct care staff completed the training and in 2014 only 20/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 67/126 direct care staff had completed the training and in 2014 only 58/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for falls prevention and management in November 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in falls prevention and management. (575)

2. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for the Skin and Wound Care Program. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered

on the following dates: July 18, 2013 and April 17, 22, 23, 2014. The records indicated that in 2013 only 3/126 direct care staff completed the training and in 2014 only 14/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 83/126 direct care staff had completed the training and in 2014 only 52/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for skin and wound care in December 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in skin and wound care. (575)

3. Inspector #543 requested staff training records for direct care staff (RN, RPN, PSW) for Continence Care and Bowel Management. The inspector reviewed the 2013 and 2014 staff training records for the home and noted that training was offered on the following dates: August 12, 2013 and May 5, 6, 2014. The records indicated that in 2013 only 9/126 direct care staff completed the training and in 2014 only 16/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 63/126 direct care staff had completed the training and in 2014 only 68/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for continence care in October 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff are provided annual training in continence care and bowel management (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff who provide direct care to residents receive annual training in behaviour management.

This plan is to include but not be limited to the timeframes by which the training in the above will occur and be completed by.

The plan shall be submitted by January 30, 2015 and fully implemented by May 31, 2015.

The plan shall be submitted in writing to Lindsay Dyrda, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, ON, P3E 6A5 or Fax at 705-564-3133.

Grounds / Motifs :

1. Inspector #575 requested staff training records for direct care staff (RN, RPN, PSW) for Responsive Behaviours. The inspector reviewed the 2013 and 2014 education records for the home and noted that training was offered on the following dates: October 23, 2013 and February 5, 11, 20, 21, 2014. The records indicated that in 2013 only 13/126 direct care staff completed the training and in 2014 only 21/126 direct care staff completed the training to date. The inspector asked the Site Administrator to confirm the numbers and they indicated that in 2013 only 101/126 direct care staff had completed the training and in 2014 only 89/126 direct care staff had completed the training to date. The Site Administrator indicated that the home has planned education for responsive behaviours in November 2014. The number of staff who completed the annual training varied between the staff training records obtained by the inspector and the numbers provided by the Site Administrator, nonetheless training was incomplete.
The licensee has failed to ensure that all direct care staff receive the required training annually, specifically regarding behaviour management. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

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

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

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 12th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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