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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 30, 2015	2015_380593_0006	#S-000763-15	Follow up

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 2, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff training records and home policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 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. 19. (1)	CO #001	2014_380593_0017	593

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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #002 that sets out the planned care for the resident.

During an interview with Inspector #593 April 2, 2015, #s-106 advised that in February 2015, resident #002 made a complaint about #s-106 providing rough care. As a result, #s-106 told the inspector that they no longer provide primary care for this resident. #S-106 further advised that since this incident, the DOC stated that it would be better for two people to provide care for this resident. They also told Inspector #593 that the resident has special care needs specific to this resident.

During a phone interview with Inspector #593 April 9, 2015, the DOC confirmed that an internal investigation was completed for this incident as soon as they were made aware of the incident and several interventions were put into place as a result. They further added that the resident has special care needs specific to this resident and will usually have issues with care provided unless staff provide these special care needs.

A review of the home's investigation undertaken February 6, 2015 found that as a result, several interventions were put in place to provide specialized care to resident #002.

During an interview with Inspector #593 April 2, 2015, #s-103 advised that resident #002 has special care needs and staff have to ensure that they provide the specific care needs for this resident. #S-103 further added that they also have specific transfer requirements to meet the care needs of the resident.

A review of resident #002's current plan of care found that the resident has special care needs and staff are to ensure that these specific care needs are met through several interventions documented in the care plan.

During a phone interview with Inspector #593 April 9, 2015, the DOC stated that due to a system upgrade, all of their resident information had not yet been entered back into the system, including new information. As a result, new interventions related to resident #002's care have not yet been added to the written plan of care.

The resident's current plan of care does not mention numerous interventions that were initiated as a result of the incident occurring in February, 2015. This included special care needs and interventions to manage these specific needs. As such, the licensee has

failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident. [s. 6. (1) (a)]

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 plan of care (POC) for resident #002 sets out the planned care for the resident specifically regarding the manner in which the resident is to receive care, to be implemented voluntarily.

WN #2: 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. The licensee has failed to immediately report the abuse of a resident to the Director.

During an interview with Inspector #593 April 2, 2015, #s-106 told the inspector that in February 2015, resident #002 made a complaint about #s-106 providing rough care. As a result, #s-106 said that they no longer provide primary care for this resident.

A review of the Critical Incident (CI) system by Inspector #593 found no CI submitted for this incident.

During a phone interview with Inspector #593 April 9, 2015, the DOC confirmed that an internal investigation was completed for this incident as soon as they were made aware of the incident and as a result, several interventions were put in place to improve care to resident #002. The DOC also confirmed that they did not report this incident to the Director.

A review of the home's investigation found that in February, 2015, resident #002 was found crying by #s-103. #S-103 asked the resident what was wrong and they responded that their caregivers in the morning rush them and they find them rough. #S-103 reported the allegations to the on-duty RN, #s-104. #S-103 reported the incident to registered staff member #s-105 the following day, #s-105 advised to #s-103 that they were not aware of the issue. #S-105 then notified the DOC about this incident two days later. The DOC commenced an internal investigation that day.

During a phone interview with Inspector #593 April 9, 2015, the DOC advised that when the allegations were initially reported to #s-104, #s-104 spoke with the resident but found that their allegations were not legitimate and so did not report them further to the management of the home.

During an interview with Inspector #593 April 2, 2015, #s-109 stated that last week they received a complaint from resident #001 that #s-102 was rough with care, kept the call bell away from them and would not take them to the washroom when they needed to go. #S-109 advised that they reported this to the on-duty RN at the time.

A review of the Critical Incident (CI) system by Inspector #593 found no CI submitted for this incident.

During a phone interview with Inspector #593 April 9, 2015, the DOC confirmed that an internal investigation was completed for this incident as soon as they were aware of the incident and that the findings did not support the allegations of abuse. The DOC also confirmed that they did not report this incident to the Director.

A review of the home's investigation found that resident #001's family member reported allegations to the on-duty RN #s-111 in March, 2015. The allegations included that #s-102 called the resident a degrading name and was going into their room when they

were not supposed to. The DOC commenced an internal investigation.

A review of the home's policy "Zero Tolerance of Abuse and Neglect" review date September 15, 2014 found the following: that the home will report to the MOHLTC Director the results of every investigation it conducts under this policy and any action that it takes regarding any incident of resident abuse or neglect and that section 24 (1) of the LTCHA requires a person to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur.

Non-compliance was previously identified in inspection 2014_380593_0017, pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report the verbal abuse by a staff member towards two residents in the home.

The licensee received allegations regarding two different incidents involving alleged abuse towards residents by staff members. Neither incident was reported to the Director. [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 ensuring that if the home is made aware of alleged, suspected or witnessed abuse or neglect of a resident by anyone, that the suspicion and the information upon which it is based is to be immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

During an interview with Inspector #593 April 2, 2015, #s-106 told the inspector that in February 2015, resident #002 made a complaint about #s-106 providing rough care. As a result, #s-106 advised that they no longer primarily care for this resident.

During a phone interview with Inspector #593 April 9, 2015, the DOC confirmed that an internal investigation was completed for this incident as soon as they were made aware of the incident. The DOC also confirmed that they did not report this incident to the Director.

A review of the home's investigation found that in February, 2015, resident #002 was found crying by #s-103. #S-103 asked the resident what was wrong and they responded that their caregivers in the morning rush them and they find them rough. #S-103 reported the allegations to the on-duty RN, #s-104. #S-103 reported the incident to registered staff member #s-105 the following day, #s-105 advised to #s-103 at this time that they were not aware of the issue. #S-105 then notified the DOC about this incident two days after the allegations were initially brought forward by the resident. The DOC commenced an internal investigation that day.

During a phone interview with Inspector #593 April 9, 2015, the DOC stated that when the allegations were initially reported to #s-104, they went and spoke with the resident but found that the allegations were not legitimate and so did not report them further to the management of the home as per the "Zero Tolerance of Abuse and Neglect" policy. The DOC also confirmed that they did not report this incident to the Director.

During an interview with Inspector #593 April 2, 2015, #s-109 stated that last week they received a complaint from resident #001 that #s-102 was rough with care, kept the call bell away from them and would not take them to the washroom when they needed to go. #S-109 advised that they reported this to the on-duty RN at the time.

A review of the home's investigation found that resident #001's family member reported allegations to the on-duty RN #s-111 in March, 2015. The allegations included that #s-102 called the resident a degrading name and was going into their room when they were not supposed to. The DOC commenced an internal investigation however, as

confirmed by #s-109, the allegations were reported to them the week prior.

A review of the home's policy "Zero Tolerance of Abuse and Neglect" review date September 15, 2014 found the following: that the home will report to the MOHLTC Director the results of every investigation it conducts under this policy and any action that it takes regarding any incident of resident abuse or neglect and that any employee or volunteer who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately to the Director of Care/Administrator/Delegate, who will ensure a thorough and confidential investigation is initiated.

The licensee has failed to comply with multiple aspects of their own policy "Zero Tolerance of Abuse" review date September 15, 2014 including immediate reporting to the Director and notification of the DOC / Administrator/ Delegate immediately by any employee or volunteer who witnesses, or becomes aware of, or suspects resident abuse. [s. 20. (1)]

Issued on this 30th day of April, 2015

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

Original report signed by the inspector.