Ontario

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

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
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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| **Date(s) of inspection/Date de l'inspection** | **Inspection No/ d'inspection** | **Type of Inspection/Genre d'inspection** |
|---|---|---|
| April 13, 2011 | 2011_188_3039_12Apr100421 | Follow-up Inspection, S- 001181-11 |

**Licensee/Titulaire**
St. Joseph's Health Centre of Sudbury, 1140 South Bay Road, Sudbury, P3E 0B6, FAX:705-673-1009

**Long-Term Care Home/Foyer de soins de longue durée**
St. Gabriel's Villa of Sudbury, 4690 Municipal Road 15, Chelmsford, ON, P0M 1L0, FAX: 705-673-1009

**Name of Inspector(s)/Nom de l'inspecteur(s)**
Melissa Chisholm (188)

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow-up inspection.

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care, registered staff members, personal support workers and physiotherapy assistants

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed the care of residents, reviewed the health care record of resident's in the home, reviewed required postings within the home and observed medication storage areas.

The following Inspection Protocols were used during this inspection:
Admission Process
Responsive Behaviours
Falls Prevention
Medication

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

**Findings:**

1. Inspector reviewed the health care record for a resident on April 13, 2011. The progress notes identify multiple incidents of the resident having a responsive behaviour. A behaviour resident assessment protocol (RAP) identifies the resident as having this behaviour and the need to care plan for this behaviour. The plan of care for the resident does not include this behaviour or any directions to respond to this behaviour. The licensee failed to provide clear direction to staff in respect to the resident's behaviour.

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| **Inspector ID #:** | 188 |

**WN #2:** The Licensee has failed to comply with O.Reg. 79/10, s.53(1)(2) Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

**Findings:**

1. Inspector reviewed the health care record for a resident on April 13, 2011. The progress notes identify multiple incidents of the resident having a responsive behaviour. A behaviour RAP identifies the resident as having this behaviour and the need for interventions for this behaviour. The plan of care for this resident does not include written strategies including techniques to prevent, minimized or respond to the behaviour. The licensee failed to provide written strategies including techniques and interventions, to prevent, minimize or respond to the resident's behaviour.

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| **Inspector ID #:** | 188 |

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| **Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné** | **Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** |
| **Title:** **Date:** | **Date of Report:** (if different from date(s) of inspection).<br>April 18, 2011 |