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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2018	2018_655679_0032	002536-18, 005634-18, 006242-18, 011968-18, 013411-18, 031487-18, 031818-18, 031827-18	Critical Incident System

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

MICHELLE BERARDI (679), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 26 - November 30, 2018.

The following intakes were inspected upon during this Critical Incident System Inspection:

- Three intakes submitted to the Director for disease outbreaks in the home;
- One intake submitted to the Director for unlawful conduct between two residents;
- Two intakes submitted to the Director for alleged abuse towards residents; and,
- Two intakes submitted to the Director for resident falls.

A Complaint Inspection (2018_655679_0031) and a Follow up Inspection (2018_655679_0030) were conducted concurrently with this inspection.

Inspector #736 was present throughout the course of the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Admissions Coordinator, Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RNs), RPNs, Personal Care Assistant (PCAs), residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

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

6 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was documented: the provision of the care set out in the plan of care.

Inspector #684 reviewed a Critical Incident (CI) report which was submitted to the Director related to a fall for resident #003. The CI report identified that resident #003 fell and sustained an injury.

Inspector #684 reviewed a health care record for resident #003 from a specified month, for a number of fall prevention interventions and noted missing documentation for a specified number of shifts indicating if the interventions were provided. A further review of the specified health care record for resident #003 from a different month, identified missing documentation on a specified number of shifts for a fall prevention intervention.

During an interview held with PCA #116 they informed Inspector #684 that resident #003 had a number of fall prevention interventions in place. Inspector #684 asked PCA #116 if they documented on these interventions, and if so, where they were documented. PCA #116 stated they would find the information in the care plan, and they document in Point Of Care (POC) charting.

Inspector #684 also interviewed RPN #105 who stated that there should have been no blanks on the POC charting.

Inspector #684 reviewed the policy titled "Documentation" last reviewed June 1, 2018, which identified that documentation provided evidence that care requirements had been met, and that the interventions of team members had been delivered. The policy further identified that nursing staff were to document on POC as soon as possible after the event

had occurred.

Inspector #684 spoke to the DOC regarding POC charting for resident #003, and they confirmed that there should have been no blanks in the POC charting. [s. 6. (9) 1.]

2. Inspector #684 conducted a follow-up to compliance order #001 from inspection #2018_657681_0006 which required a review of resident #010's care plan.

Inspector #684 reviewed resident #010's specified health care record over a specified number of months and noted missing documentation on a number of shifts indicating if the interventions were provided.

During an interview held with PCA #104, they informed Inspector #684 that if a resident had fall prevention interventions in place, this would be documented in POC. Inspector #684 asked PCA #104 if there would ever be a time when POC documentation would not be completed to which they answered there should be no blanks in POC, and if there were blanks the person did not chart.

Inspector #684 also interviewed RPN #105 who stated after review of the specified health care record, that there should have been no blanks on the POC charting.

Inspector #684 spoke to the DOC regarding POC charting for resident #010, they confirmed that there should have been no blanks in the POC charting. [s. 6. (9) 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 the provision of care set out in the plan of care related to fall prevention interventions for residents is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies, pain, risk of falls, and other special needs.

Inspector #684 reviewed a CI report which was submitted to the Director related to a resident fall. Within the report it was noted that at the time of the fall there were no fall prevention measures in place.

Inspector #684 reviewed the resident's care plan which was in place at the time of the fall and noted that there was no care plan focus, goals, or interventions related to falls for resident #004.

Inspector #684 reviewed the progress notes and discovered that resident #004 had a specified number of previous falls. The progress note identified that after the first fall the resident's account of how the fall happened was listed as a specified reason.

During an interview with RN #103 they stated that a care plan for falls would be started on admission, if the resident was at moderate to high risk, but that they believed it was a requirement to have it in the care plan for everyone pertaining to Morse falls risk scale.

Inspector #684 reviewed Falls Prevention and Management Program (issue date: June 1, 2009). In the procedure section it was written "Based on the risk level of low, moderate, high, or very high, a fall risk care plan is initiated/ updated".

During an interview held between the DOC and Inspector #684 regarding falls prevention, they stated they would create a fall care plan for a resident who was noted to have a specified health condition and that the resident should have been reassessed. The DOC confirmed that resident #004 should have had a fall care plan and that was missed. [s. 26. (3) 10.]

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 the plan of care is based on, at a minimum, an interdisciplinary assessment of the residents risk of falls, to be implemented voluntarily.

WN #3: 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):
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. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of the following incident in the home: an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A) A CI report was submitted to the Director on June 11, 2018, for an outbreak of a reportable or communicable disease. The CI report identified that the outbreak was declared on June 9, 2018, two days before the submission of the CI report.

Inspector #679 reviewed the home's internal CI report file regarding this outbreak and identified a document from Public Health Sudbury and Districts (PHSD) which identified that due to reports of symptoms affecting the residents of the home, an outbreak was declared on June 9, 2018.

B) A CI report was submitted to the Director on June 1, 2018, for an outbreak of a reportable or communicable disease. The CI report identified that the outbreak was declared on May 30, 2018, two days before the submission of the CI report.

Inspector #679 reviewed the home's internal CI report file regarding this outbreak and identified a document from PHSD which identified that due to reports of symptoms affecting the residents of the home, an outbreak was declared on May 29, 2018.

C) A CI report was submitted to the Director on October 26, 2018, for an outbreak of a reportable or communicable disease. The CI report identified that the outbreak was declared on October 24, 2018, two days before the submission of the CI report.

Inspector #679 reviewed the home's internal CI report file regarding this outbreak and identified an email from the homes Administrator dated October 24, 2018, which identified that the public health unit had declared a specific type of outbreak.

A review of the policy entitled "Critical Incident" last revised December 13, 2017, identified that an outbreak of reportable or communicable disease was to be reported immediately using the on-line CIS reporting system on weekdays and via the after-hours pager all other times and on statutory holidays.

In an interview with the ADOC, who was also the infection control lead, they identified that an outbreak would be reported to the Director either the day of the outbreak or the next day. Inspector #679 reviewed the CI reporting dates with the ADOC. The ADOC identified that they were aware the reporting requirements which stipulated that outbreaks were to be reported to the Director immediately. [s. 107. (1) 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 any outbreak of a reportable or communicable disease as defined in the Health Protection and Promotion Act is reported to the Director immediately, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded.

Two CI reports were submitted to the Director for reportable or communicable disease outbreaks in the home. Each CI report identified that there were a specified number of confirmed cases of illness during the outbreak.

A) Inspector #679 reviewed an outbreak "Line Listing" document which identified that there were a specified number of residents who were exhibiting symptoms.

Inspector #679 reviewed the progress notes for residents #007 and #008 and identified documentation to be missing on a specified number of shifts.

B) Inspector #679 reviewed an outbreak "Line Listing" document which identified that there were a specified number of residents who were exhibiting symptoms.

Inspector #679 reviewed the progress notes for resident #011 and identified documentation to be missing on a number of shifts.

In an interview with RN #101 they identified that symptoms were monitored on every shift and that they would be documented in the progress notes.

In an interview with the ADOC, who was also the infection control lead, they identified that symptoms were monitored on every shift and that they would be documented in the progress notes. Together, Inspector #679 and the ADOC reviewed the progress notes. The ADOC confirmed that there was no documentation on the specified dates. [s. 229. (5) (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 on every shift, symptoms indicate the presence of infection in residents are recorded, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident had the right to meet privately with his or her spouse or another person in a room that assured privacy.

A CI report was submitted to the Director for an incident of unlawful conduct. The CI report identified that residents #001 and #002 were observed meeting privately. The CI report further identified that measures were in place to prevent the residents from meeting privately.

Inspector #679 reviewed the electronic progress notes which identified that the residents would previously meet in private. The progress notes detailed resident #001 and #002's responses to having a staff member intervene when the residents tried to meet privately.

Inspector #679 reviewed resident #001's electronic care plan which identified a specified focus, and interventions to manage the resident trying to meet privately with resident #002.

Inspector #679 reviewed resident #002's electronic care plan which identified a specified

focus, and interventions to manage the resident trying to meet privately with resident #001.

In an interview with PSW #110 they identified that the residents would be upset when staff would get involved or try to prevent them from meeting privately. PSW #110 identified that there was specified interventions in place to manage the residents from meeting privately.

In an interview with RPN #102 they identified that the residents would be upset that staff were trying to separate them.

In an interview with Behavioural Supports Ontario (BSO) RPN #108 they identified that the home had implemented specified interventions to manage the resident's from meeting privately. BSO RPN #108 identified that the residents would be upset when staff intervened from them meeting privately.

A review of the homes policy identified that every resident/patient had the right to meet privately with their spouse/partner or another person in a room that assures privacy.

In an interview with the DOC they identified that the home had put interventions in place to manage the interactions of resident #001 and #002. The Inspector asked if the residents were upset that they were being separated, to which the DOC responded that they were upset that they were being separated.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually related to the Residents' Bill of Rights.

Inspector #679 reviewed the education record titled "MOH Resident Rights Report" for 2017, which identified there were four staff members who had not completed their resident right education for 2017.

A review of the policy entitled "Zero Tolerance for Abuse and Neglect", last revised July 6, 2018, identified that the resident's bill of rights and the policy on zero tolerance of abuse or neglect was to be reviewed with each new employee during orientation and annually thereafter.

In an interview with the DOC they provided the inspector with the "MOH Resident Rights Report" training record. The DOC confirmed that this training was to be completed annually, and that four staff members had not completed their education. [s. 76. (4)]

Issued on this 20th day of December, 2018

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

Original report signed by the inspector.