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
Jun 10, 2019	2019_752627_0011	010979-19, 011030-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

Long-Term Care Home/Foyer de soins de longue durée

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 4-6, 2019.

The following intakes were inspected during this Complaint Inspection:

- One Complaint, submitted to the Director, regarding resident to resident physical abuse.

- One Critical Incident System (CIS) intake related to the same issue (resident to resident abuse) was inspected during the Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Assistants (PCAs), residents and their families.

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

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report and a Complaint were submitted to the Director in regards to a potential resident to resident altercation between residents #001 and #002. The complainant reported concerns regarding the incident.

Inspector #627 reviewed resident #002's care plan in effect at the time of the inspection, which indicated that a specific intervention was to be in place when the resident was in their room alone.

Inspector #627 reviewed the home's policy titled, "Careplanning", issued September 29, 2003, which indicated that the "Interprofessional team members [were] to provide care to the resident as set out in the plan".

On a specific date and time, Inspector #627 observed resident #002's room door closed. The resident was observed by the Inspector sleeping in their bed. The specific intervention had not been applied.

At a later date and time, Inspector #627 observed the resident sleeping in their bed. The specific intervention had not been applied.

In separate interviews with Inspector #627, Personal Care Assistants (PCAs) #101 and #103 stated that the specific intervention should have been applied when resident #002 was in their room.

Inspector #627 interviewed Registered Practical Nurse (RPN) #105 who stated that resident #002 was to have the specific intervention in place when they were in their room.

Inspector #627 interviewed the Director of Care (DOC) who acknowledged that the specific intervention was to be in place when resident #002 was in their room, and that care had not been provided as per the resident's care plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 10th day of June, 2019

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

Original report signed by the inspector.