Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 16, 2020	2020_679687_0006	004782-20, 008150-20, 010256-20	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

LOVIRIZA CALUZA (687)

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): June 1, 8-12, 15-18, and 23 -26, 2020.

The following intakes were inspected during this Critical Incident System (CIS) Inspection.

- Three intakes related to missing controlled substances.

A Complaint Inspection # 2020_679687_0007 and a Follow-up Inspection # 2020_679687_0005 were conducted concurrently with this inspection.

PLEASE NOTE: A Written Notification and Compliance Order related to s 8 (1) (b) of the Ontario Regulation (O. Reg) 79/10, was identified in this inspection and has been issued in Inspection Report 2020_679687_0007, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set (MDS) Coder, Personal Care Assistants (PCAs), Food Service Assistants (FSAs), Kitchen Cook, family members and residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection: Medication

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. (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 has failed to ensure that the provision of the care set out in the plan of care was documented.

1) The home submitted a Critical Incident (CI) report to the Director related to resident #001's missing specified medication.

Inspector #687 conducted a review of resident #001's specified medication monitoring in the electronic Medication Administration Record (eMAR) and identified that the staff did not document having assessed the medication on two separate dates.

A review of the home's specific medication policy indicated that the Registered Practical Nurse (RPN) would assess the medication at identified times and frequency and would be documented in the eMAR.

An interview was conducted by Inspector #687 with Registered Nurse (RN) #103, RN #106 and RPN #110, they all indicated that resident #001's specified medication was checked at a specific schedule; documented in the resident's eMAR, and the home had implemented an additional enhanced monitoring check.

During an interview conducted by Inspector #687 with the Assistant Director of Care (ADOC), the ADOC stated that the resident's plan of care covers all aspects found in the resident's chart and electronic records. The ADOC acknowledged that on two separate dates, there were no documentation record found regarding resident #001's medication check and the registered staff should have documented this in the eMAR or in the resident's electronic progress notes but this did not occur.

2) The home submitted a CI report to the Director related to resident #003's missing specified medication.

Inspector #687 conducted a review of resident #003's specified medication monitoring in the electronic Medication Administration Record (eMAR) and identified that the staff did not document having assessed the medication on three separate dates.

An interview was conducted by Inspector #687 with RN #103, RN #106 and RPN #110, they all indicated that resident #003's specified medication was checked at a specified schedule; documented in the resident's eMAR, and the home had implemented an additional enhanced monitoring check.

During an interview conducted by Inspector #687 with the Assistant Director of Care (ADOC), the ADOC acknowledged that on specified dates, there were no documentation record of resident #003's medication check and the registered staff were to document this in the eMAR or in the resident's electronic progress notes but this did not occur. [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 to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 21st day of July, 2020

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

Original report signed by the inspector.