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
Feb 23, 2022	2022_824736_0001	001851-22	Proactive Compliance Inspection

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

AMANDA BELANGER (736), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 31-February 4, 2022, and February 7-8, 2022. Off site activities took place February 8-10, 2022.

During the course of the inspection, the inspector(s) spoke with the Site Administrator, Director of Care (DOC), Environmental Services Manager, the previous Infection Prevention and Control (IPAC) Lead, the IPAC Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Aids, Personal Support Workers (PSWs), Personal Care Aides (PCAs), Housekeeper, family members, and residents.

The Inspector(s) conducted daily tours of the resident care areas, reviewed relevant resident records and policies, Infection Prevention and Control (IPAC) practices, Resident and Family Council meeting minutes, observed resident rooms, resident common areas, dining areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **5 WN(s)**
- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure the home was a safe and secure environment for the residents.

A) The Inspector observed a Personal Care Assistant (PCA) redirecting a resident back into their room. The Inspector noted an additional Infection Prevention and Control (IPAC) precaution signage on the resident's door. The Inspector noted that the PCA did not have the required personal protective equipment (PPE) on prior to interacting with the resident, including no eye protection.

In an interview with the PCA, they indicated that the resident was on additional IPAC precautions. The PCA further indicated that they were to wear PPE prior to interacting with residents who required additional IPAC precautions.

B) The Inspector observed a Personal Support Worker (PSW) enter a resident's room. The resident had an additional IPAC precaution sign on their door. The PSW did not put on the required PPE prior to entering the resident's room.

In an interview with the PSW, they indicated that the resident required additional IPAC precautions, and that they should have put on the appropriate PPE, including gown, gloves and eye protection, prior to entering the room.

There was risk to the residents by the staff members not wearing the appropriate PPE when interacting with residents.

Sources: Inspector's observations; licensee policy titled "Initiating Isolation and Additional Precautions", last reviewed October 2021; interview with the PCA, PSW , DIrector of Care (DOC) and other staff. [s. 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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug was to be destroyed that was not a controlled substance, it was done by a team acting together and composed of: one member of the registered nursing staff, and another staff member appointed by the Director of Nursing.

Interviews completed with a Registered Practical Nurse (RPN), and a Registered Nurse (RN), identified that when they destroyed and denatured medications that were not considered controlled substances, there was not a second staff member to witness the disposal.

The DOC identified they were not sure when the practice had started, and that the home had been short staffed and understood the requirement to have two staff present when non-controlled medications were destroyed and disposed of.

The failure of not having two staff present when destroying and discarding medications that were not controlled substances presented no harm to residents; however, without the proper process, there was a risk of medication diversion.

Resources: Policy for “Drug Destruction and Disposal” last revised on November 2020; interviews with the DOC, RN, RPN, and other staff. [s. 136. (3) (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 to ensure that when a drug is destroyed that is not a controlled substance, it is done by a team acting together and composed of one member of the registered nursing staff and another staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, related to resident hand hygiene, staff hand hygiene and additional precautions being taken.

A) Inspectors observed meal service on different units and identified staff were not assisting residents to clean their hands before or after meals. The home’s Hand Hygiene program was based on the Just Clean Your Hands (JCYH) program, which required that staff assist residents to clean their hands before and after meals, snacks, and activities.

The IPAC lead, and IPAC assistant identified that staff had a process in place, to assist residents with their hand hygiene.

The DOC identified that staff were required to offer residents hand hygiene before meals.

B) A review of the home's COVID-19 Management Guidelines, indicated that eye protection was to be worn by staff at all times.

The Inspection observed a RPN administer medication to a resident without eye protection on.

The RPN indicated to the Inspector that they were to have eye protection on when interacting with residents.

C) The Inspector observed a PSW enter a resident room, who was on additional IPAC precautions at the time.

The PSW did not complete hand hygiene prior to entering the room, or after leaving the room.

The failure of staff not providing hand hygiene before and after meals, as well as not washing their own hands, and not wearing eye protection presented a minimal risk to residents.

Sources: Inspectors observations; licensee policy titled "Hand Hygiene"; interviews with the PSW, RPN, the DOC, the previous IPAC Lead; IPAC assistant and other staff; the home’s policy, Hand Hygiene policy, last reviewed October 2021, and the home’s internal COVID-19 Management Guide. [s. 229. (4)]

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 staff participate in the IPAC program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received a bath twice weekly, unless otherwise indicated by their plan of care.

Progress notes indicated that the resident did not receive a bath for a two week period, as the tub on the home area was not in working order. There was no indication of any additional baths being attempted during that time period.

In an interview with the RPN, they indicated that there was no documentation to support that the resident had received any baths during the identified time period.

There was minimal risk to the resident by not receiving a bath twice weekly.

Sources: The resident's progress notes, care plan and Point of Care documentation; licensee policy titled "Bathing-Complete, Partial, Tub Baths and Showers", last reviewed September 3, 2021; interview with the RPN, DOC and other staff. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

During an observation, the Inspector noted the medication cart to be unlocked and unattended near the nursing station during the breakfast meal service. The Inspector noted the nurse to be in the back of the dining room, with their back to where the medication cart was left. There were students, instructors and maintenance staff in and around the area of the medication cart during the time it was left unlocked and unattended.

There was risk of medication diversion with the medication cart being left unlocked and unattended in a common area of the home.

Sources: Inspector observations; licensee policy titled "The Medication Cart and Storage Maintenance", last updated February 2017; interview with DOC and other staff. [s. 129. (1) (a) (ii)]

Issued on this 24th day of February, 2022

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

Original report signed by the inspector.