Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 23, 2023	
Inspection Number: 2023-1467-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: St. Joseph's Health Centre of Sudbury	
Long Term Care Home and City: St. Gabriel's Villa of Sudbury, Chelmsford	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature** Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.02.02 12:36:05 -05'00'
Additional Inspector(s) Steven Naccarato (744) Justin McAuliffe (000698) was present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 9-13, 2023

The following intake(s) were inspected:

- Two intakes, related to allegations of resident to resident physical abuse;
- One intake, related to a responsive behaviour of a resident;
- Two intakes, related to falls that resulted in injuries;
- One Intake, which was a complaint related to falls prevention management;
- One Intake, which was a complaint related to the management of responsive behaviours.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Notification re incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was notified immediately of an allegation of resident to resident abuse.

There was an incident involving two residents, during which they both sustained minor injuries, and a Critical Incident (CI) was submitted for an allegation of resident to resident abuse. The resident's SDM was not notified of the incident until the following day.

A Registered Nurse (RN), and the Director of Care (DOC) both stated that if there was an incident which resulted in an injury and a CI had been submitted, then the SDM should have been notified at the time of the incident.

Not immediately notifying the SDM of an allegation of resident to resident physical abuse presented a low risk to the resident.

Sources: A CI report; Interviews with a RN, and the DOC.
[690]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that a door leading to a non-resident area was kept locked when not being supervised by staff.

Rationale and Summary

On an identified date, a work order was submitted to maintenance staff regarding a door leading to a

non-resident area not being able to lock. Maintenance staff were not able to identify any concerns with the door lock and the work order was closed the following day.

An incident occurred on an identified date involving a resident, related to the door not being locked. Another work order concerning the same door was created the same day due to the door not being able to lock; however, the issue concerning the door lock was not resolved until three days later.

The Administrator stated that doors to non-resident areas must be always locked, due to the potential hazards to residents that were inside the rooms. They also stated that the door lock should have been fixed immediately, with measures in place to ensure residents were safe until the concern was resolved.

The door leading to a non-resident area not being locked, was a moderate risk for the resident.

Sources: A resident's electronic health records; Two Work orders; Interviews with the Administrator and other staff.
[744]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 29 (3) 5.

The licensee has failed to ensure that a resident's specified responsive behaviour was identified in the plan of care.

A resident's progress notes identified multiple incidents of a specified responsive behaviour towards staff and other residents in the last three months. The resident's electronic care plan on Point Click Care (PCC) did not include any information related to the specified responsive behaviour.

A Personal Care Assistant (PCA), and a RN verified that the resident did have the specified responsive behaviour. The RN and, DOC stated that the information should be included on the care plan.

Not having information on the care plan related to the specified responsive behaviour presented a low risk to the resident.

Sources: A resident's progress notes; Interviews with the DOC and other staff.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (c)

The license has failed to ensure that a resident's responses to interventions for the management of responsive behaviours was documented, specifically completing an identified assessment tool.

A resident's Physician had ordered documentation to be completed on the identified assessment tool for a period of time. A review of the documentation indicated that it had not been fully completed.

PCA staff indicated that they had not completed the documentation as per the instructions on the identified assessment tool. An RN, and the DOC also confirmed that the documentation was not completed as per the Physician's order.

Not fully completing the documentation for the resident as order by the Physician, presented a moderate risk to the resident.

Sources: A resident's Physician's Orders; a resident's documentation; Interviews with PCA staff, RN, and the DOC.
[690]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (ii)

The licensee has failed to ensure that a resident's mobility aid had been cleaned, and disinfected when it was visibly soiled, or as per the established schedule.

During observations of the resident, the inspectors noted that the resident's mobility aid was heavily soiled. A PCA stated that they were aware of the state of the mobility aid, and that it had been like that for some time. The following day, it was noted to be in the same condition. Point of Care (POC) documentation for the resident indicated that the mobility aid was to have been cleaned on a weekly

basis and had not been cleaned the previous week.

A Registered Practical Nurse (RPN), and the DOC stated that the mobility aid should have been cleaned if it was visibly soiled, and as per the established schedule.

A Resident's mobility aid not being cleaned and disinfected when visibly soiled presented a low risk to the resident.

Sources: Observations during the inspection; A resident's POC documentation. the home's policy titled "Mobility Aids-Cleaning Of", dated September 2003; Interviews with a PCA, RPN, and the DOC.
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