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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: November 16, 2023	
Inspection Number: 2023-1467-0006	
Inspection Type: Complaint Critical Incident	
Licensee: St. Joseph's Health Centre of Sudbury	
Long Term Care Home and City: St. Gabriel's Villa of Sudbury, Chelmsford	
Lead Inspector Steven Naccarato (744)	**Inspector Digital Signature** Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2023.11.17 15:51:28 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3-6, 10-11, 2023

The following intake(s) were inspected:

- One intake was related to a complaint regarding the care of a resident.
- One intake was related to a complaint regarding the potential neglect of a resident.
- One intake was related to the abuse of a resident by a staff member.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary
A Personal Support Worker (PSW) witnessed another PSW abuse a resident.

The Administrator had indicated that after their investigation of the incident was concluded, the allegation of resident abuse was substantiated.

The home's failure to protect the resident from abuse caused minimal harm.

Sources: The home's investigation notes; The resident's health care records; Interview with the Administrator and other staff.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee has failed to ensure that the improper care of a resident was reported immediately to the Director.

Rationale and Summary
The home's management was aware of a concern regarding the unsafe transfer of a resident, causing pain to the resident.

The incident was not immediately reported.

The home's failure to immediately report improper care of a resident to the Director was minimal risk.

Sources: A Critical Incident (CI); Interview with the Administrator and other staff.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that safe transferring techniques were used to assist a resident.

Rationale and Summary
A resident was transported in an unsafe manner.

The Assistant Director of Care (ADOC) indicated that the resident was not transported according to their plan of care.

The home's failure to ensure safe transferring techniques to assist the resident caused minimal harm to the resident.

Sources: The resident's health care records; the homes investigation notes, complaint letter, the home's policy titled "Lifts and transfer-Minimal lift, one person pivot/Use of transfer board, use of mechanical lifts" issue date June 24, 2011; Interviews with the ADOC and other staff.

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