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: February 15, 2024
Inspection Number: 2024-1467-0001
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	**Inspector Digital Signature**
Jessamyn Spidel (000697)	Jessamyn Jean Spidel Digitally signed by Jessamyn Jean Spidel Date: 2024.03.11 09:26:37 -04'00'

Additional Inspector(s) Steven Naccarato (744)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-18, 2024

The following intake(s) were inspected:
- Intake: #00099326 - Alleged abuse of residents by staff.
- Intake: #00100440 - COVID-19 Outbreak.
- Intake: #00101788 - Complainant concerns regarding installation of a device.
- Intake: #00102018 - Complainant concerns regarding alleged improper care of resident.

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

Resident Care and Support Services

Ministry of Long-Term Care
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Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iii.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and

The licensee has failed to ensure a resident's right to participate fully in making any decision concerning any aspect of their care, specifically regarding the use of a device in their room.

Rationale and Summary

A complaint was submitted to the Director concerning the home's refusal of the use of a device in a resident's room.

The Substitute Decision Maker (SDM) for a resident wanted a device to be placed in the resident's room.

The SDM was in the process of setting up a device in the resident's room when a Registered Nurse (RN) had explained to the SDM that it was against the home's policy to install a device in a resident room.

During a meeting with the DOC, the DOC denied the SDM use of a device in the resident's room.

The home's failure to ensure that the resident participated fully in making the decision concerning a device's use in their room, caused minimal risk to the resident.

Sources: Complaint intake; Resident's electronic health records; Home policies related to devices in patient/resident rooms; Interviews with the DOC and other staff. [744]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)
Plan of care
s. 6 (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care.

The licensee has failed to ensure that a resident's SDM was given an explanation of the resident's plan of care.

Rationale and Summary

A complaint was submitted to the Director outlining care concerns for a resident, and a lack of communication from the home regarding the resident's health condition.

A resident had a change in condition which prompted a change in medication. The SDM was not immediately notified of the resident's change in condition which required the medication change.

An RN indicated that as per the home's policy and the resident's plan of care, the resident's SDM should have been immediately notified of the plan.

The home's failure to ensure that the SDM was given an explanation of resident's plan of care, caused minimal harm to the resident.

Sources: Complaint intake; Resident's electronic health records; Digital Prescriber's orders on a specified date; The home's policy titled "Consent to Treatment"; Interviews with a RN, and other staff. [744]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from emotional abuse by an identified staff member.

Specifically, O. Reg 246/22 s. 2 (1) (a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
Review of the home's internal investigation file into allegations of abuse by an identified staff member toward a resident, confirmed emotional abuse allegations had been substantiated by the home.

Interviews with the Administrator and Assistant Director of Care (ADOC) confirmed the results of the investigation supported the finding of emotional abuse by the staff member toward a resident.

Sources: Review of Critical Incident (CI) reports, After Hours (AH) report; Home's internal investigation files; Home's policy titled Zero Tolerance for Abuse and Neglect; and interviews with Administrator, ADOC, and other staff. [000697]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is

complied with.

Rationale and Summary
Review of the home's internal investigation file into allegations of abuse by an identified staff member toward residents, confirmed that witnesses who reported the allegations of abuse did not immediately report as required.

An interview with a staff member, confirmed they witnessed abusive behaviour by the identified staff member towards a resident and others on multiple occasions, and did not immediately report the allegations as required.

Interviews with the Administrator and ADOC confirmed two staff members did not immediately report allegations of abuse as required, and confirmed that the home immediately reported the allegations and initiated an investigation once they became aware.

Sources: Review of CI reports, AH report; Home's internal investigation files; Home's policy titled Zero Tolerance for Abuse and Neglect; and interviews Administrator, ADOC, and other staff. [000697]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Specifically, section 1.2 of Minister's Directive: COVID-19 response measures for long-term care homes requires staff, students, volunteers, and support workers are required to wear masks indoors in all resident care areas.

Rationale and Summary
Observations made over a period of time, identified multiple staff wearing masks below their noses or mouth, while providing direct care to residents.

Interviews with staff confirmed that staff are required to wear a surgical mask that is fitted over their nose and mouth while in resident care areas and when providing direct care to residents.

Interviews with the Infection Prevention and Control (IPAC) Lead and ADOC, further confirmed that the home requires staff to wear surgical masks covering their nose and mouth.

Sources: Review of CI report, and AH report; Review of signage in the home; Observations; Interviews with ADOC, IPAC Lead, and other staff. [000697]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes requires,

Section 10.2 (c) required the licensee to implement a hand hygiene program for residents, ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks; and Section 10.4 (h) required the licensee to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: Support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary
Disposable wet toilette hand wipes and Alcohol Based Hand Rub (ABHR) were observed at the entrance to the dining room along with signage reminding staff to offer hand hygiene to residents before meals.

Observations made of three meal services confirmed that hand hygiene was not consistently being offered or provided to residents in the dining room before meals and snacks. Specifically, hand hygiene was not offered or provided to residents during observations of two out of three meal services.

A review of the home's IPAC Policies indicated that the home did not have a policy which included resident hand hygiene.

Interviews with the IPAC Lead and Administrator confirmed that residents should be offered hand hygiene in the dining room prior to meals and snacks, and that the

home did not have a policy for resident hand hygiene as required.

Sources: Review of CI report, and AH report; Review of signage in the home; Review of IPAC Policies including the home's Hand Hygiene policy; Observations; Interviews with Administrator, IPAC Lead, ADOC, and other staff. [000697]