Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2013	2012_138151_0021	S-000878-12	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

MONIQUE BERGER (151)

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): December 12,13,14, 2012

Critical Incidents reviewed are as follows:
S-000878-12 related to CI: 3039-000015-12
S-000828-12 related to CI: 3039-000009-12
S-000978-12 related to CI: 3039-000018-12
S-001019-12 related to CI: 3039-000019-12
S-000790-12 related to CI: 3039-000010-12
S-000948-12 related to CI: 3039-000017-12

During the course of the inspection, the inspector(s) spoke with - Site Administrator, Director of Care,VP of Clinical Services, RNs, RPNs,PSWs (Personal Support Workers), Activity Aide, residents

During the course of the inspection, the inspector(s)
- did daily walk-through of the home, with emphasis on assuring home's implementation of falls management program,
- reviewed resident health care records,
- reviewed home's abuse policies and procedures,
- reviewed home's policies and procedures in regards to falls management,
- reviewed the home's falls management program,
- reviewed the home's related education initiatives for the last 12 months,
- audited resident health care records for completed post-fall assessments,
- directly observed care and service delivery to residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident?
O.Reg.79/10,s. 104. (1) 2.

The home filed a report of alleged resident abuse with the Ministry. Inspector noted that the report was vague in reference and did not include the following required information:
- details in reference to the reported incident of abuse,
- names of the resident(s) involved in the alleged report of abuse, and,
- identification of the staff member(s) alleged to have abused the resident(s) [s. 104. (1) 2.]

Issued on this 3rd day of January, 2013

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

Monique G. Bugu (151)