Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2013_211106_0020
Log No. / Registre no:	S-000247-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 7, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jo-Anne Palkovits

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_099188_0015, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure the care set out in the plan of care is provided to residents #001, specifically regarding activities and monitoring when resident is eating or drinking and #002, specifically regarding oral intake.

Grounds / Motifs :

1. Two previous Written Notifications (WN) of non-compliance with voluntary plans of correction (VPC) under LTCHA 2007, S. O. 2007, c. 8, s. 6 (7) have been issued in February 2013 during inspection #2013_138151_0004 and in May 2013 during inspection # 2013_140158_0007(A1).

One Compliance Order (CO) under LTCHA 2007, S. O. 2007, c. 8, s. 6 (7) has previously been issued in June 2013 during inspection # 2013_0099188_0015, CO #002. (106)

2. The inspector reviewed the health care record for resident #002 and it is documented in the plan of care that resident is to be monitored for increased choking/coughing/aspiration, positioned in a specific manner during and after any oral intake and resident to have crustless bread. On August 8, 2013, during the evening snack pass at approximately 1950 hrs a PSW was observed taking a sandwich and hot chocolate into the resident's room. On August 8, 2013, at 2020 hrs, the inspector entered the resident's room and observed the resident asleep in their bed and not positioned as described in their plan of care, with part of the half eaten sandwich in their hand. The sandwich that was in the resident's hand had the crust on the bread. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the

plan. (106)

3. The inspector reviewed the health care record for resident #001 and it is documented in the plan of care that staff are to provide constant 1:1 supervision while eating/drinking. On August 7, 2013, during the lunch service, resident #001 was observed to eat and drink without a staff member providing constant 1:1 supervision. Staff members that were present in the dining room were busy assisting other residents or serving food. On August 8, 2013 during the dinner service staff were observed to set the resident up and provide intermittent assistance/supervision but did not provide constant 1:1 supervision while the resident was eating and drinking. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (106)

4. The inspector reviewed the health care record for resident #001 and it is documented in the plan of care that the resident is to participate in 1 activity program a week. The "Multi-Day Participation Report" from July 5, 2013 to August 5, 2013 for resident #001 was reviewed. The report indicated that the resident only attended 2 activity programs during that time, once on July 19, 2013 and again on July 31, 2013. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to activities. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 16, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of October, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MARGOT BURNS-PROUTY

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2013	2013_211106_0020	S-000247-13	Follow up

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 6, 7, 8, 9, 2013

Logs reviewed during this inspection, Log # S-000247-13.
Concurrent complaint inspection # 2013_211106_0021 completed during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Manager of Food Services, Manager of Environmental Services, Registered Nurse (RN), Registered Practical Nurse (RPN), Physiotherapist (PT), Physiotherapist Assistant (PTA), Activity Lead, Family Members, and Residents

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The inspector reviewed the health care record for resident #001 and it is documented in the plan of care that the resident is to participate in 1 activity program a week. The "Multi-Day Participation Report" from July 5, 2013 to August 5, 2013 for resident #001 was reviewed. The report indicated that the resident only attended 2 activity programs during that time, once on July 19, 2013 and again on July 31, 2013. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to activities. [s. 6. (7)]

2. The inspector reviewed the health care record for resident #001 and it is documented in the plan of care that staff are to provide constant 1:1 supervision while eating/drinking. On August 7, 2013, during the lunch service, resident #001 was observed to eat and drink without a staff member providing constant 1:1 supervision. Staff members that were present in the dining room were busy assisting other residents or serving food. On August 8, 2013 during the dinner service staff were observed to set the resident up and provide intermittent assistance/supervision but did not provide constant 1:1 supervision while the resident was eating and drinking. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

3. The inspector reviewed the health care record for resident #002 and it is documented in the plan of care that resident is to be monitored for increased choking/coughing/aspiration, positioned in a specific manner during and after any oral intake and resident to have crustless bread. On August 8, 2013, during the evening snack pass at approximately 1950 hrs a PSW was observed taking a sandwich and hot chocolate into the resident's room. On August 8, 2013, at 2020 hrs, the inspector entered the resident's room and observed the resident asleep in their bed and not positioned as described in their plan of care, with part of the half eaten sandwich in their hand. The sandwich that was in the resident's hand had the crust on the bread. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. Two previous Written Notifications (WN) of non-compliance with Voluntary Plans of Correction (VPC) under LTCHA 2007, S. O. 2007, c. 8, s. 6 (7) have been issued in February 2013 during inspection #2013_138151_0004 and in May 2013 during inspection # 2013_140158_0007(A1).

One Compliance Order (CO) under LTCHA 2007, S. O. 2007, c. 8, s. 6 (7) has

previously been issued in June 2013 during inspection # 2013_0099188_0015, CO #002. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_099188_0015	106

Issued on this 8th day of October, 2013

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