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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 20, 2018	2018_760527_0024	003104-18, 020616-18	Critical Incident System

Licensee/Titulaire de permis

Clurelea Ltd.
c/o Good Samaritan Nursing Home 481 Victoria Street East Alliston ON L9R 1J8

Long-Term Care Home/Foyer de soins de longue durée

Good Samaritan Nursing Home
481 Victoria Street East Alliston ON L9R 1J8

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

KATHLEEN MILLAR (527)

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): November 13, 14, 15 and 16, 2018.

The following critical incidents were inspected:

Log #003104-18, related to continence care; and
Log #020616-18, related to an alleged staff to resident abuse.

Inquiries completed included:

Log #021991-18, an anonymous complaint related to short staffing; and
Log #025314-18, related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Nursing, Director of Resident Care (DRC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant clinical records, various licensee policies, procedures, program plans, staff training records and the home's internal investigation files.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On a specific date in July 2018, resident #004 was being provided care by PSW #102 and PSW #103. There was no privacy curtains drawn between resident #004 and resident #003. PSW #104 walked into the room and requested the other PSWs draw the privacy curtains between the residents when providing personal care.

PSW #103 was interviewed and acknowledged that they provided the evening care to resident #004 and they did not provide privacy to the resident when providing care.

PSW #104 was interviewed and acknowledged that there was no privacy provided to resident #004, when evening care was provided.

The Administrator was interviewed and acknowledged that resident #004 was not provided with privacy when PSW #102 and #103 were providing evening care to resident #004 and were expected to draw the privacy curtains.

The licensee failed to ensure that resident #004 was afforded privacy in treatment and caring for their personal needs.

Issued on this 29th day of November, 2018

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

Original report signed by the inspector.