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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2015	2015_202165_0001	008346-14	Complaint

Licensee/Titulaire de permis

SAINT LUKE'S PLACE
1624 Franklin Blvd. CAMBRIDGE ON N3C 3P4

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

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD CAMBRIDGE ON N3C 3P4

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 6, 2015

During the course of the inspection, the inspector(s) spoke with Registered staff, Personal Support Workers, Dietary Aide, Director of Care, Chief Executive Officer and residents

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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	Legendé 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In 2014, resident #001 reported that a Personal Support Worker spoke to them in a sarcastic, yelling tone and an argument ensued. The resident reported that they felt the staff member was yelling, since it was loud enough that everyone in the area could hear. The resident reported that they felt hurt, embarrassed and did not feel that being treated in that manner was warranted.

The identified Personal Support Worker confirmed that the resident was yelling at the time and the resident was visibly upset. The Personal Support Worker reported that they raised their voice above the resident who was yelling at the time. The Personal Support Worker confirmed that to the resident their responses could be perceived as yelling.

Personal Support Workers in the area confirmed that the resident was visibly upset and was observed crying. The identified Personal Support Worker was heard yelling at the resident by staff. A Personal Support Worker reported that the resident was still crying when they finished their shift one hour later and the expectation would be that staff would use a more dignified approach.

The resident was not treated with courtesy, respect and in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Prevention, Reporting and Elimination of Resident Abuse Policy, QI-20-140-A-07-I-05 indicated that shouting or inappropriate tone of voice and manner of speaking which was upsetting to the resident met the home's definition of verbal abuse. The policy indicated that the Director of Care would investigate all incidents of alleged, suspected or witnessed abuse, document the incident on the resident's chart, document all aspects of the investigation and report the matter to the Ministry of Health and Long Term Care.

In 2014, a Registered staff member reported to the Director of Care that an identified Personal Support Worker was yelling at a resident and the resident was visibly upset.

Interview with the Director of Care confirmed that an investigation to the alleged verbal abuse,documentation of the incident on the resident's chart, documentation of all aspects of the investigation and a report to the Ministry of Health and Long Term Care were not completed as indicated in the home's policy. [s. 20. (1)]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.