Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 23, 2011 Revised July 6, 2011	2011-120 -8564-23Mar090257	Critical Incidents - H-03112, H-03113, H-00408, H-00363, H-00374

Licensee/Titulaire

St. Joseph's Health System, 574 Northcliffe Ave, Dundas, ON L9H 7L9

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

St. Joseph's Health Centre, 100 Westmount Road, Guelph, ON N1H 5H8

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

Bernadette Susnik - Environmental Health #120 and Debora Saville, Nursing #192

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct an inspection related to Critical Incident Reports that were submitted to the Ministry of Health and Long-term Care.

During the course of the inspection, the inspectors spoke with the acting Director of Care, Personal Support Workers and Nursing staff.

During the course of the inspection, the inspectors reviewed abuse policies and procedures, staff records, staff training materials on abuse and resident records.

The following Inspection Protocol was used during this inspection:

- *Prevention of Abuse, Neglect and Retaliation*

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activities

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with the LTCHA 2007, S.O., 2007, c.8, s.24(1)2.*** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

Two incidents, occurring on the same day, involving the verbal abuse of two separate identified residents was not reported until four days after the occurrence.

An incident involving the verbal abuse of another identified resident was not reported until two days after the occurrence.

An incident involving an attempted resident to resident physical abuse by an identified resident was not reported until eight days after the occurrence. (Identified by Inspector #192)

WN #2: ***The licensee has failed to comply with the LTCHA, 2007, S.O., 2007, c.8, s.19.*** 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.

Findings:

A staff member treated an identified resident with impatience and forcefulness when the resident refused to go to bed. On the same date, the same staff member also made inappropriate comments to the resident while conducting personal care. The staff member was suspended. Upon return to work, the staff member was given counseling on the home's zero tolerance on abuse. However, on a subsequent date, the same staff member verbally abused another identified resident by yelling at them. The incident was witnessed by another staff member. The staff member responsible for the incidents was terminated.

On another date, a resident was yelled at by another staff member. The staff member was suspended.

Signature of Licensee of Designated Representative Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Revised for the purpose of publication - Sept 29, 2011
Title: **Date:**	**Date of Report :**(if different from date(s) of inspection).