



**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

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

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspektion
November 16, 17, and 18, 2010	2010_192_8564_16Nov105047 2010_192_8564_17Nov105201 2010_192_8564_18Nov113314	Critical Incident H - 01073 Critical Incident H - 01793 Critical Incident H - 01797

Licensee/Titulaire
St. Joseph's Health System, 574 Northcliffe Ave, Dundas, Ontario, L9H 7L9

Long-Term Care Home/Foyer de soins de longue durée
St. Joseph's Health Centre, 100 Westmount Road, Guelph, Ontario, N1H 5H8

Name of Inspector(s)/Nom de l'inspecteur(s)
Marilyn Tone Nursing Inspector # 167 Debora Saville Nursing Inspector # 192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct critical incident inspections.

During the course of the inspection, the inspectors spoke with: Chief Executive Officer (CEO), Vice President (VP) of Clinical Services, Director of Care (DOC), Registered Practical Nurses', Personal Support Worker's and residents.

During the course of the inspection, the inspectors: Reviewed clinical records, policy and procedure, incident investigations, and training records.

The following Inspection Protocols were used during this inspection: Responsive Behaviours, Prevention of Abuse and Neglect, Reporting and Complaints and Critical Incident Response.

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 envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

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'écrit de l'exigences prévue le paragraph 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA , 2007, S.O. 2007, c. 8 s23(2)

A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Findings:

The Director has not received the results of internal investigations and actions taken related to incidents reported through the Critical Incident System. In discussion with the Director of Care (DOC) it was confirmed that results of the investigation conducted and actions taken for these incidents were not reported to the Director.

Inspector ID #: Marilyn Tone Nursing Inspector # 167, Debora Saville Nursing Inspector # 192

WN #2: The Licensee has failed to comply with O. Reg. 79/10 s103(1) and (2)

103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

(2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director.

Findings:

A written complaint and the report documenting the response the licensee made to the complainant was not forwarded to the Director on two occasions.

Inspector ID #: Marilyn Tone Nursing Inspector # 167, Debora Saville Nursing Inspector # 192



Signature of Licensee or Representative of Licensee 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.	
		<i>Deborah Swill</i>	
Title:	Date:	Date of Report: (if different from date(s) of inspection).	
		<i>December 22, 2010</i>	