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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, 2016	2015_30610a_0021	023382-15	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

IRENE SCHMIDT (510a)

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): December 22, 2015, January 4 and 5, 2016.

This complaint inspection was conducted related to a complaint regarding abuse of a resident. Critical incident #2975-000032-15 is correlated to this complaint.

During the course of the inspection, the inspector(s) spoke with managers and directors of care.

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.

- **1 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. 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 that promotes zero tolerance

of abuse and neglect of residents was complied with.

A) Policy # POL/9, titled Abuse/Neglect of a Resident, revised 10/11/2015, directed that "if, as judged by the manager/director/administrator on call or site president, the circumstances are sufficiently serious to warrant immediate suspension of the implicated employee, this action may be taken. The employee may be off work pending investigation."

Review of the homes internal records revealed that there were three complaints related to an identified staff member in which residents described feeling fearful and scared after interactions with the staff member.
1) on an identified date, a specified resident complained about verbal abuse from an identified staff member. An internal investigation did not substantiate the allegation.
2) on a later identified date, another specified resident complained that they were fearful after an interaction with the identified staff member. The staff member was counseled.
3) on another later identified date, another specified resident reported being fearful and scared after interactions with the identified staff member.
As a result of the third report, the manager reassigned the identified staff member to another unit. Payroll records revealed the staff member worked two more shifts immediately following the third complaint and had care encounters with a specified resident during that time. The manager and DOC confirmed that the third complaint was a circumstance sufficiently serious to warrant immediate suspension of the implicated employee and the staff member should have been sent home pending the results of the investigation. The home's policy that promotes zero tolerance of abuse and neglect of residents was not complied with.

B) Policy # POL/9, titled Abuse/Neglect of a Resident, revised 10/11/2015, directed that "the charge nurse, manager/supervisor investigating the incident documents a detailed report describing the situation and including what, where, who, when and how: ensure that the Ministry of Health, Critical Incident System is notified as per protocol, depending on events that have allegedly occurred".

Clinical record documentation reported that on a specified dated in July 2015:
1) an identified resident was advised by staff that if they went to bed before lunch, they would not be assisted back up from bed for lunch and that they would not receive lunch.
2) the identified resident was not assisted up for lunch and was denied lunch.
3) registered staff spoke with resident and family to reassure that what happened was inappropriate, that the resident had every right to lay down for a rest when desired and

that they should not have been denied a meal.
The home's internal investigation confirmed the resident was left in bed and did not receive lunch.
The incident was not reported through the Ministry of Health Critical Incident System.
The manager and DOC confirmed that the home's policy that promotes zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with., to be implemented voluntarily.

Issued on this 15th day of January, 2016

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

Original report signed by the inspector.