

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 le Loi de 2007 les foyers de soins de longue

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

Hamilton Service Area Office 119 King Street West, 11th Floor HAMILTON, ON, L8P-4Y7 Telephone: (905) 546-8294 Facsimile: (905) 546-8255 Bureau régional de services de Hamilton 119, rue King Ouest, 11iém étage HAMILTON, ON, L8P-4Y7 Téléphone: (905) 546-8294 Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 8, 9, 16, 17, 24, Mar 7, 2012	2012_060127_0008	Critical Incident
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	I, L9H-5G7	
Name of Inspector(s)/Nom de l'inspec	teur ou des inspecteurs	
RICHARD HAYDEN (127)		
İnsı	oection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with residents, the director of care and the assistant director of care regarding H-002556-11.

During the course of the inspection, the inspector(s) reviewed management's documentation of the incidents and records from an employee's personnel file.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

MON COMPLIANCE / NO.		
NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
Legend	[Legende: street and the street and	
WN - Written Notification	WN = Avis écrit	
VPC - Voluntary Plan of Correction	VPC - Plan de redressement volontaire	
DR - Director Referral	DR Alguillage au directeur	
	CO = Ordre de conformité	
	the state of the s	
WAO – Work and Activity Order	IWAO – Ordres : travaux et activités	
	불러한 한다. [편집 한다면 다른 전쟁 100 전	



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 le Loi de 2007 les fovers de soins de longue

Non-compliance with requirements under the Long-Term Care the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le non-respect des exigences de la Loi de 2007 sur les foyers de Homes Act, 2007 (LTCHA) was found. (A requirement under the soins de longue durée (LFSLD) a été constaté. (Une exigence de la LTCHA includes the requirements contained in the items listed in 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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 19. Duty to protect Specifically failed to comply with the following subsections:

s. 19. (1) 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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants:

1. The licensee failed to protect residents from abuse by anyone. On February 08, 2012, the inspector spoke with the director of care and the assistant director of care. Five residents alleged that an identified health care worker (HCA) was rough and aggressive during residents' care. Three of five residents were cognitively well and were interviewed by a registered practical nurse in 2011.

Complaint forms submitted on behalf of the residents and typed notes by the resident care coordinator regarding the identified HCA indicated that the HCA was very aggressive and rough when providing care and this resulted in pain and injury to the residents.

On February 08, 2012, the inspector spoke with two of the residents. Both stated that the identified HCA was very rough and caused pain during care.

Issued on this 7th day of March, 2012

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