Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 3, 2021	2021_563670_0018	007860-21, 010857-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village at St. Clair
1800 Talbot Road Windsor ON N9H 0E3

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

DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 14, 15, 19, 20, 21, 22, 23, 26, 27, 28 and 29, 2021.

This inspection was completed to inspect the following;
Log# 010857-21 Critical Incident System report #3046-000024-21 related to allegations of a staff member taking photos of a resident.
Log# 007860-21 Critical Incident System report #3046-000017-21 related to a fall with injury.
This inspection was completed concurrently with complaint follow up inspection #2021_563670_0017

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, two Neighborhood Coordinators, five Personal Support Workers, two Registered Practical Nurses and residents.

During the course of this inspection the Inspector observed the overall cleanliness and maintenance of the home, observed infection prevention and control practices, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records, reviewed relevant policies and procedures and reviewed relevant internal documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention

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	Légende 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 has failed to ensure that resident #002 and #003 were treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

The licensee submitted a Critical Incident System (CIS) report related to a report that Personal Support Worker (PSW) #106 had taken videos of resident #002 and #003 and had sent the videos to Registered Practical Nurse (RPN) #108.

Review of the homes internal investigation notes show that the home was able to establish that PSW #106 took videos of residents #002 and #003 and sent the videos to RPN #108. RPN #108 then reported this to Neighborhood Coordinator #105. Residents #002 and #003 were assessed and experienced no adverse effects.

During an interview with the General Manager (GM) #100 they acknowledged that PSW #106 did not treat resident #002 and #003 with courtesy or respect and did not respect the resident's dignity.

The failure to treat resident #002 and #003 with courtesy or respect and failure to respect the resident's dignity placed resident #002 and #003 at risk.

Sources: CIS report, the home's investigation notes, interview with GM #100. [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 the following rights of residents are fully respected and promoted; 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.

Issued on this 4th day of August, 2021

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

Original report signed by the inspector.