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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2014	2014_228172_0021	003068-14	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2

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

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S
21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6

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

JOAN WOODLEY (172)

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): November 13, 14, 18, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care, 2 Directors of Resident Care, 2 Registered Nurses, 5 Registered Practical Nurses, 14 Primary Care Providers (PCP), 2 Housekeeping Aides, and 1 Housekeeping Supervisor.

During the course of the inspection, the inspector(s) toured the home, made observations, reviewed records, policies and other relevant documents.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to live in a safe and clean environment is fully respected and promoted.

Observations revealed an unattended housekeeping bucket, full of water with a mop in the bucket sitting in the hallway.

Interview with a PCP confirmed a bucket was sitting in the hallway, unattended, full of water and had a mop standing up in the bucket.

Interview with a member of the registered staff confirmed a bucket was sitting in the hallway, unattended, full of water and had a mop standing up in the bucket.

Neither PCP nor the member of the registered staff addressed the concern after the inspector identified it to them.

Interview with a Housekeeping aide confirmed she/he always leaves a bucket full of water with a mop in it for the nurses to access when she/he is on break. She/he shared not all nursing staff would have a key to access the housekeeping room

Interview with a Housekeeping Supervisor revealed:
a) it is not the home's expectation that a housekeeping bucket full of water and a mop in it be left in the hallway and unattended when the housekeeping aide is on break
b) nursing staff, at least the registered staff would have a key to the housekeeping room where the bucket should be stored

Interview with the Director of Resident Care revealed:

a) there is no reason for the housekeeper to leave a bucket full of water with a mop in it, in a hallway when he/she goes on break.
b) the registered staff have a key to the housekeeping room.
c) the nursing staff should have addressed the unattended bucket when the Inspector showed it to them
d) it is the home's expectation that all staff provide for the safety of residents.

Interview with the Director of Long Term Care revealed:
a) it is not the home's expectation that a housekeeping bucket full of water and a mop would be left unattended in the hallway of the resident home area.
b) it is the home's expectation that all staff are to provide for the safety of residents. [s. 3. (1) 5.]

2. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs be respected and promoted.

Observations revealed a member of the registered staff completing a treatment on a resident who was sitting in the dining room waiting for lunch.

Interview with the member of the registered staff revealed this was not the usual practice to complete a treatment in the dining room

Interview with the Director of Resident Care revealed it is the home's expectation that a treatment would be completed in a private place and not in the dining room, in front of other residents. [s. 3. (1) 8.]

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 resident's right to live in a safe and clean environment is fully respected and promoted and to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs be respected and promoted, to be implemented voluntarily.

Issued on this 20th day of November, 2014

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