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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2014	2014_202165_0025	000571-14/003542-14	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
574 Northcliffe Avenue, DUNDAS, ON, L9H-7L9

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

ST JOSEPH'S HEALTH CENTRE, GUELPH
100 WESTMOUNT ROAD, GUELPH, ON, N1H-5H8

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

TAMMY SZYMANOWSKI (165)

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): September 24, 2014

Critical incident 000571-14 and 003542-14 were conducted simultaneously

During the course of the inspection, the inspector(s) spoke with the Director of Care and Registered Nursing Staff

During the course of the inspection, the inspector(s) reviewed resident clinical health records, policies and procedures, investigation notes and observed care areas

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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:
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 of the long term care home failed to ensure that 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.

In June 2014, two Personal Support Workers were attempting to get resident #001 up and provide morning care.

During the morning care one Personal Support Worker was heard using inappropriate voice level, tone and words which was directed at the resident. The resident was heard from outside of their room asking the Personal Support Worker to stop.

This was verified by the Personal Support Workers who reported that the resident was not listening to them and they were trying to get the resident up otherwise they would be in bed all day if they did not try and make a routine.

Resident #001 was not treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

An assessment for resident #002 indicated the resident had behaviours related to wandering. The resident's plan of care related to mobility indicated the resident was dependent on one staff for mobility.

In August 2014, resident #002 was taken to the dining room by a Personal Support Worker. Approximately, 15 minutes later the resident was found by staff in another resident's room.

The Director of Care verified that resident #002's plan of care was not based on the behaviour assessment related to the resident's wandering and mobility. [s. 6. (2)]

Issued on this 26th day of September, 2014

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