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

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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 19, 2014	2014_289550_0015	O-000304-14	Critical Incident System

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

JOANNE HENRIE (550)

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): June 25, 26 and 27, 2014.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care and a resident.

During the course of the inspection, the inspector(s) Reviewed a resident's health records, a critical incident report and the home' internal investigation report.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Skin and Wound Care

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 has failed to ensure that the licensee fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Resident #001 is a very alert resident who is dependent of staff for all of his/her personal care and requires a wheelchair for his/her mobility related to a specific diagnosis.

During an interview, Resident #001 explained to Inspector #550 he/she had an excoriated area for a long time and that sometimes it is painful when pericare is provided to him/her. He/she indicated that on a specific date in March 2014, PSW staff #S100 was providing pericare to him/her and this area was very painful when the PSW was washing him/her. Resident #001 indicated to staff #S100 to stop the care as the area was very painful and he/she was crying. Staff #S100 stopped briefly but continued despite the resident's request indicating to resident he/she had to wash the resident. Resident #001 became very upset as the employee did not respect his/her wish. Resident #001 reported the incident to the Administrator and requested this employee does not care for him/her anymore.

During an interview, the Administrator indicated to Inspector #550 PSW staff #S100 should have respected Resident #001's request to stop washing him/her as the care being provided was causing him/her pain and he/she was crying. The Administrator indicated to inspector that PSW #001 was disciplined as a result of his/her actions and he/she is no longer caring for Resident #001 as per the resident's request.

Staff #S100 received training on Resident's Rights on March 26th, 2014. [s. 3. (1) 1.]

Issued on this 20th day of October, 2014

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