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

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

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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
May 2, 2014	2014_306510_0010	H-000372-14 H-000494-14	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 25, 28, 29, 30, 2014

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Nursing Care, Assistant Director of Nursing Care, Neighbourhood Coordinators, Registered Nurses, Registered Practical Nurses, Personal Support Workers

During the course of the inspection, the inspector(s) observed activity in neighbourhoods throughout the home, spoke with residents and family members and conducted record reviews

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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

On an identified date in 2014, Resident #1 reported that a Personal Support Worker (PSW) had been bullying them by making inappropriate remarks towards them such as "I can't wait to get away from you".
The resident was interviewed and confirmed that the PSW had bullied them and they felt harassed by the PSW.
Review of the Critical Incident Report – Analysis and Follow-up and the Internal Complaint Investigation documentation revealed the employer determined the staff member "violated the Resident's Bill of Rights by making inappropriate comments toward a resident which caused an alarm/fear to resident and diminished their sense of safety and security".
PSW was interviewed and acknowledged that Resident #1 felt harrassed by the comments they made and apologized to the resident.
PSW received a disciplinary suspension for violating the Resident's Bill of Rights.
Director of Nursing (DON) confirmed the staff member did not fully respect and promote the resident's rights. [s. 3. (1) 2.]

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Issued on this 21st day of May, 2014

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

Irene Pasel