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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2015	2014_250511_0028	H-001551-14	Critical Incident System

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

ROBIN MACKIE (511)

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): December 2, 2014.

CI# 2927-000069-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered staff, Personal Support Worker's (PSW's) Resident Advisor and resident.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 following rights of residents were fully respected and promoted: 1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

During an interview with resident #001, they identified they felt their care was provided inappropriately and in an undignified manner, causing feelings of disrespect, uneasiness and fear on an evening in 2014 . A review of the resident's clinical records, Ministry of Health-Critical Incident report and the home's internal investigation records indicated the continence care, provided by a direct care staff member of the opposite sex, was provided in a manner that did not respect the resident's right to their dignity. On an evening in 2014, between the hours of 2100-0600 hours, the direct care staff member approached the resident, in their bed, to change their incontinent brief. The resident stated they were completely wet and required their clothing to be changed. The resident stated they did not recognize the direct care staff member when they entered their room alone, they did not state their name and the resident felt uncomfortable and fearful when the staff member proceeded to totally undress them by removing their wet clothing followed by their brief. During the course of the care, the staff member left the resident completely naked on the bed while they went to get them dry clothing. The resident stated they were uncomfortable with being totally naked, the manner in which the care was provided and made it known to the staff member on their return. The PSW acknowledged the resident's uncomfortable feelings by making a comment, which increased the resident's level of unease, and continued to complete the care by washing the resident. An interview with the Administrator indicated the direct care staff member was not working in the home at the time of the inspection. The Administrator confirmed the home did not ensure the resident's dignity was respected when a staff member left resident #001 exposed on the bed during their continence care and continued to provide care despite knowing the resident's level of unease. The Administrator further acknowledged the direct care staff member did not respect the resident's right to be treated with courtesy and respect when they proceeded to make a comment to the resident that implied they had 'at least' a good looking young person of the opposite sex that provided their care. [s. 3. (1) 1.]

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Issued on this 9th day of February, 2015

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

Original report signed by the inspector.