Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 25, 26, 2011	2011_116_2556_25May104828	Critical Incident Log 1042-11

Licensee/Titulaire

Chartwell Master Care LP
100 Milverton Drive, Suite 700
Mississauga, ON
L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
The Gibson Long Term Care Centre, 1925 Steeles Avenue east, Toronto ON M2H 2H3

Name of Inspector(s)/Nom de l'inspecteur(s)
Saran Daniel-Dodd, Inspector 116

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection regarding alleged staff to resident abuse.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Resident Services, Director of Clinical Services, Registered and direct care staff members.

During the course of the inspection, the inspector: Reviewed the health record of a resident, reviewed in service records on training related to safe lifts and transfers and zero tolerance for abuse.

The following Inspection Protocols were used in part or in whole during this inspection:
Prevention of Abuse, Neglect and Retaliation
Falls Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007. s. 6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings:

- **The care plan specifies the resident requires assistance to be provided by two person(s) and the usage of a hoyer lift for all transfers.**
- **Resident's transferring requirements as per plan of care were not followed.**

Inspector ID #:	116

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 care set out in the plan of care is provided to all residents as specified in the plan. To be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg 79/10 s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:

- **Plan of care for resident identifies requirement for all transfers to be provided by two persons with the use of a hoyer lift.**
- **Resident's transferring requirements as per plan of care were not followed.**

Inspector ID #:	116

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 staff use safe transferring and positioning devices or techniques when assisting residents. To be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). June 16, 2011