

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division

Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 13, 16, 20, Oct 11, 2011	2011_026147_0023	Complaint
Liconoco/Tituloiro do normio		

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

FAITH MANOR NURSING HOME 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistance Director of Care and Resident related to Complaint Inspection Log #H-001573-11

During the course of the inspection, the inspector(s) Reviewed resident's clinical chart, observed care and home's policy and procedure regarding Prevention of Abuse.

The following Inspection Protocols were used during this inspection: Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES			
Legend	Legendé		
WN – Written Notification	WN – Avis écrit		
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire		
DR – Director Referral	DR – Aiguillage au directeur		
CO - Compliance Order	CO – Ordre de conformité		
WAO – Work and Activity Order	WAO - Ordres : travaux et activités		



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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)	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. 19. Duty to protect Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. An identified resident was admitted to the home in 2011. Since admission the resident was subject to abuse by a visitor. The progress notes confirm these concerns were verbalized to the home's staff on numerous occasions by the resident in 2011, and that this interaction was upsetting to them. The home failed to protect the resident from abuse by anyone.

Additional Required Actions:

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 ensure the home shall protect all residents from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

4. Misuse or misappropriation of a resident's money.

5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. An identified resident was admitted to the home in 2011. Since admission the resident was subject to abuse by a visitor. The progress notes confirm these concerns were verbalized to the home's staff on numerous occasions by the resident in 2011. The home had knowledge that the resident was being abused, however, failed to report the matter to the director.



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Issued on this 24th day of November, 2011

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