

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****Long-Term Care Operations Division  
Long-Term Care Inspections Branch****Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**Central West Service Area Office  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 16, 2020	2020_796754_0018	001129-20	Complaint

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**Licensee/Titulaire de permis**Golden Dawn Senior Citizen Home  
80 Main Street Lion's Head ON N0H 1W0**Long-Term Care Home/Foyer de soins de longue durée**Golden Dawn Nursing Home  
80 Main Street Lion's Head ON N0H 1W0**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

TAWNIE URBANSKI (754)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): July 6, 7, 8, 2020.**

**The following intakes were completed during this Complaint inspection:  
Log #001129-20, related to an alleged incident of abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN's), Registered Practical Nurses (RPN'S), Personal Support Workers (PSW's), and residents.**

**The inspector observed resident care and resident/staff interactions. A record review of the plan of care of the identified residents was completed. The home's relevant investigation and related documentation were also reviewed.**

**The following Inspection Protocols were used during this inspection:  
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**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: 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:**

**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. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee failed to immediately report the allegations of abuse towards resident #001 to the Director.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care (MLTC) in January 2020, related to an incident of alleged incident of abuse towards resident #001. The incident occurred in January 2020.

Administrator #100 said they were aware of the alleged incident of abuse in January 2020. They said a CI report should have been submitted immediately but was submitted five days late.

The licensee failed to immediately report the allegations of abuse towards resident #001 and failed to provide the information upon which it was based to the Director. [s. 24. (1)]

**Issued on this 21st day of July, 2020**

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

**Original report signed by the inspector.**