



**Ministry of Health and  
Long-Term Care**

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

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**  
**Division des foyers de soins de  
longue durée**  
**Inspection de sions de longue durée**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
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**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**

Bureau régional de services de  
London  
130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 15, 2016	2016_418615_0003	002277-16	Critical Incident System

**Licensee/Titulaire de permis**

ST. JOSEPH'S HEALTH CARE, LONDON  
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

Mount Hope Centre for Long Term Care  
21 GROSVENOR STREET P.O. BOX 5777 LONDON ON N6A 1Y6

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

HELENE DESABRAIS (615)

**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): January 27 -28, 2016.**

**This Critical Incident inspection Log# 002277-15/CI# C537-000033-15, C537-000027-15 and C537-000005-16 was related to prevention of abuse.**

**During the course of the inspection, the inspector(s) spoke with the home's Director, one Registered Nurse, one Social Worker, one Finance Worker, one Registered Practical Nurse, one Personal Support Worker and a Detective from the London Police department.**

**The Inspector also reviewed the resident's clinical record, the home's investigation and other relevant documentation.**

**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)**



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**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).

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



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**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 Director of the home who had reasonable grounds to suspect that misuse or misappropriation of the resident's money had occurred failed to immediately report the suspicion and the information to the Director.

An interview with the finance worker revealed that there was only one accommodation payment made on behalf of resident #001 in five months. No other payments were made after this date and the home made multiple attempts, by phone and registered letters, to make arrangements for payments from the person managing the resident's finances.

An interview with the home's Director #100 confirmed the suspicion that there may be financial abuse of this resident. The Director confirmed that police were called and they then launched an investigation into the financial abuse.

The Director confirmed that the Ministry of Health was not contacted until a later date and it was the home's expectation to contact the Ministry immediately when suspecting the misuse or misappropriation of a resident's money. [s. 24. (1)]



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**Issued on this 16th day of March, 2016**

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

**Original report signed by the inspector.**