Ontario

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

apport 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**
September 13, 2010	2010_103_891_08Sep173917	Other (Critical Incident #0891-000015-10) Log #O-001058

Licensee/Titulaire
Revera Long Term Care, 55 Standish Court, 8th floor, Mississauga, Ontario L5R 4B2 Fax# 289-360-1201

Long-Term Care Home/Foyer de soins de longue durée
Hallowell House, 13628 Loyalist Parkway, Picton, Ontario K0K 2T0 Fax #613-476-1566

Name of Inspector(s)/Nom de l'inspecteur(s)
Darlene Murphy (ID#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to resident neglect.

During the course of the inspection, the inspector spoke with 2 residents, 3 Personal Support Workers and the Director of Care.

During the course of the inspection, the inspector reviewed 4 resident health records.

The following Inspection Protocol was used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol

☐ There are no findings of Non-Compliance as a result of this inspection.

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

1 WN

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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 Ontario Regulations 79/10, s.97

(1)Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:

1. **The licensee did not notify within 12 hours, the substitute decision makers for 4 residents of the incidents of neglect related to their continence care. At the time of this inspection, the substitute decision makers had still not been notified of the incidents of neglect.**

Inspector ID #:	103

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.** Dec 4/10 Darlene Murphy (ID #103)
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).