



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée

Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité

**Public Copy/Copie du public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2013	2013_195166_0044	000132,000 444	Critical Incident System

**Licensee/Titulaire de permis**

OAKWOOD RETIREMENT COMMUNITIES INC.  
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF TAUNTON MILLS  
3800 Brock Street North, WHITBY, ON, L1R-3A5

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

CAROLINE TOMPKINS (166)

**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): December 11, 12, 2013**

**Two critical incidents, logs O-000132-13 and O-000444-13 were inspected concurrently.**

**During the course of the inspection, the inspector(s) spoke with Residents, the General Manager, the Assistant General Manager, the RAI MDS Coordinator, Registered staff and Personal Care Aides.**

**During the course of the inspection, the inspector(s) reviewed clinical health records, the licensee's internal investigation records, the licensee's policy related to the prevention of abuse and neglect and the record of staff education related to abuse, residents' rights and mandatory reporting.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**



**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>Legendé</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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. Log O-000132-13, Log O-000444-13

There is no evidence in Resident#1 and Resident#2's clinical records or in the individual critical incident reports that the police were notified immediately of two separate incidents of staff to resident abuse.

Interview with the Assistant General Manager indicated that the licensee did not notify the police until after the internal investigations were completed. [s. 98.]



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***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 to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident., to be implemented voluntarily.***

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**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:**

**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).**

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**Findings/Faits saillants :**

**1. Log O-000132-13, Log O-000444-13**

Review of Resident #1 and #2's clinical documentation, the critical incident reports and the licensee's investigations into the separate incidents indicate the MOHLTC was not immediately notified the alleged incidents of staff to resident abuse. [s. 24. (1)]



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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act Specifically failed to comply with the following:**

**s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).**

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**Findings/Faits saillants :**

1. Log O-000132-13

Review of Resident #2's clinical documentation and the licensee's investigation into the incident indicated the alleged staff to resident abuse occurred on an identified date.

The MOHLTC was not notified of the incident until the critical incident report was submitted 46 days post incident. [s. 104.(2)]

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**Issued on this 30th day of December, 2013**

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

A handwritten signature in black ink, appearing to read "A. Stompa", written over a white background within a rectangular box.