Ontario

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

Rapport 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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **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**
August 20, 2010	2010-173-2784-19aug112549	H00514 Critical Incident Inspection

Licensee/Titulaire

Barton Retirement Inc., 1430 Upper Wellington St. Hamilton, Ontario L9A 5H3

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

The Wellington Nursing Home , 1430 Upper Wellington St. Hamilton, Ontario L9A 5H3

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

Lesa Wulff – LTC Inspector #173 – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident report inspection related to allegations of verbal and physical abuse.

During the course of the inspection, the inspector spoke with: Director of Care, Nurse Clinician, Registered staff, Resident Assessment Instrument coordinator, Personal Support workers and residents.

During the course of the inspection, the inspector: conducted a review of the clinical records, Resident Assessment Instrument – Minimum Data Set assessments and Resident Assessment Protocols, observed interactions of staff with residents. Conducted interviews with residents and staff as required.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol.

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

[2] WN
[2] VPC

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 LTCHA, 2007, S.O.2007, c.8, s.3(1)2
3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse.

Findings:

1. **An identified resident residing in the home brought forward allegations of rough handling during care, as well as accusations of both verbal and physical abuse by a staff member.**
2. **Allegations were confirmed during the internal investigation conducted by the home. The staff member was terminated as a result.**

Inspector ID #:	173

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 related to protecting residents from abuse in the home to be implemented voluntarily.

WN #2: The Licensee has failed to comply O.Reg 79/10, s8(1)b
8(1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(b)and is complied with.

Findings:

1. **Director of Care did not follow homes policy and procedure in the investigation of alleged abuse. Written statements were not taken by Director of Care, and forms provided for by the home's policy were not used.**
2. **Registered staff member on duty the night of the incident, called the Director of Care, but did not document if the Personal Support Worker was approached, sent home pending investigation or any other measures taken to ensure the safety of the resident.**
3. **Review of the home's abuse policy records could not be produced during this inspection. Two staff interviewed indicated that they had not received a review of the homes abuse policy within the last year.**

Inspector ID #:	173

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 related to the home ensuring that policy related to abuse is complied with, to be implemented voluntarily.

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.** Lisa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Oct 18/10