



**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**

**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, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255**

**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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_250511_0006	H-000790- 13, H- 000848-13	Critical Incident System

Licensee/Titulaire de permis

**DELCARE LTC INC.
4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9**

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

**CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8**

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

ROBIN MACKIE (511), LISA VINK (168)

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 9, 10, 2013.

Two critical incident inspections were completed simultaneously.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, personal support workers, registered staff, family members, residents and resident physician.

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed clinical records of specified residents and relevant policy and procedures.

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



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1. The resident was not treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

In 2013 a visitor reported that they had heard resident #002 crying and requesting assistance to be changed from a specified staff member. The visitor identified that the staff responded in an angry tone and told the resident that when their family comes, they will change you. The resident continued to cry and request assistance to which the staff responded by shouting and directed them to take their medications. The staff member did not treat the resident with respect or courtesy nor respected the dignity of the resident. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 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,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :



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1. Where the Act or this Regulation required the licensee to institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home had an "Employee Handbook, last revised July 2008" which was given to each employee on hire and reviewed on a yearly basis during the employee's annual performance appraisal. This book contained information for employees regarding the home, what they should expect from the employer and what was expected of them as employees. The Personal Conduct chapter of this book identified that "employees are prohibited from accepting gifts and/or money from residents and employees offered gifts and/or money must notify the General Manager/Administrator immediately".

Interview with resident #001, who was making all care and financial decisions independently, confirmed that they gave gifts to an employee, in 2013, which were accepted. The administrator confirmed that the employee did not report the offer of the gifts, until they were interviewed as part of an internal investigation, conducted by the home. The employee's personnel file confirmed that they most recently reviewed the home's Code of Conduct in the spring of 2013. [s. 8. (1) (b)]

Issued on this 19th day of December, 2013

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