



**Ministry of Long-Term
Care**

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

**Ministère des Soins de longue
durée**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**
**Division des opérations relatives aux
soins de longue durée**
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2020_738753_0009	001506-20	Critical Incident System

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

KATHERINE ADAMSKI (753)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 10 - 12, 2020.

**The following intakes were completed in this Critical Incident System Inspection:
Log #: 001506-20 related to provision of care.**

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Residents, and Personal Support Workers (PSW).

The inspector also toured the home, observed staff to resident care provisions, and reviewed relevant documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 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

Légende

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).

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

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19.
Duty to protect**

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

A Critical Incident was submitted to the Ministry of Long-Term Care alleging neglect of resident #001 when they were not provided care by staff over a specified period of time.

Staff identified that the resident had not been provided continence care over the specified period of time.

Video footage indicated that care had not been provided as required.

Resident #001's plan of care documented that resident #001 required an identified level of care.

The home's investigation documented that the staff member said they had not provided the required care to resident #001.

The licensee has failed to ensure that resident #001 was not neglected by staff. 2007, c. 8, s. 19 (1). [s. 19. (1)]

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 resident #001 and any other resident is not neglected by the licensee or staff, to be implemented voluntarily.



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Issued on this 29th day of May, 2020

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

Original report signed by the inspector.