



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

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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
Mar 14, 2013	2013_210169_0008	H-0000135-13	Critical Incident System

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

YVONNE WALTON (169)

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 11, 12, 13 2013

During the course of the inspection, the inspector(s) spoke with Administrator/DOC, contracted management consultants, nursing staff and residents.

During the course of the inspection, the inspector(s) reviewed clinical records, observed care and policies of the home.

The following Inspection Protocols were used during this inspection:



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**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. 23. Licensee must investigate, respond and act



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Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
 - (i) abuse of a resident by anyone,
 - (ii) neglect of a resident by the licensee or staff, or
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has not ensured that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated. The licensee became aware of allegations of abuse and neglect in 2013. Three letters of complaint were received by the administrator. The licensee did not initiate an immediate investigation upon becoming aware of the allegations. This was confirmed by the management team. [s. 23. (1) (a)]

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 that ensures that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated,, to be implemented voluntarily.



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Issued on this 14th day of March, 2013

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

Yvonne Walton