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
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☐ 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
December 15, 16, 2010	2010_116_2556_15Dec111520	Critical Incident (T2547)

Licensee/Titulaire

Chartwell Master Care LP

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

The Gibson Long Term Care Centre

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

Saran Daniel-Dodd, Nursing Inspector

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Resident Services, Director of Care, Assistant Director of Care, Registered Staff members, frontline staff members and resident's.

During the course of the inspection, the inspector: Reviewed the homes abuse policy and the health records for two residents. Discussions were held with the Administrator, Director of Care, Assistant Director of Care, Registered Nurses, frontline staff members and residents.

The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident
Prevention of Abuse and Neglect

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

1 WN
1 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 with *The Long Term Care Homes Act, 2007, S.O. 2007*, c. 8, 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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to a resident.

Findings:

- **Incidents of suspected abuse were reported to a member of the home management team.**
- **The licensee failed to report immediately to the Director an incident of suspected abuse.**

An investigation was conducted by the home's management team in regards to the incident noted above. As a result of the investigation the staff member's employment was terminated.

Inspector ID #:	116

Additional Required Actions:
VPC- pursuant to the Long Term Care Homes Act, 2007, c.8, s. 152(2) the licensee is hereby requested to prepare a written plan of correction regarding ensuring all allegations of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to a resident are immediately reported to the Director.