



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
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, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 13, 20, Nov 28, 2011	2011_067171_0022	Critical Incident

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

ST OLGA'S LIFECARE CENTRE
570 KING STREET WEST, HAMILTON, ON, L8P-1C2

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

ELISA WILSON (171)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the administrator and the director of care regarding the submission of a Critical Incident (H-001525-11).

During the course of the inspection, the inspector(s) reviewed specific policies and details of the critical incident being inspected.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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 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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had a written policy that promoted zero tolerance of abuse of residents, however it was not complied with. The home's Abuse Policy indicated all staff must report any incident or suspected incident of resident abuse and that the administrator was to be notified immediately in all cases of abuse/suspected abuse. A resident returned to the home from a leave of absence. A progress note on the day the resident returned indicated the resident was found with injuries. This suspected incidence of abuse was not reported to the administrator until two days later. The administrator confirmed this time lag in reporting this incident and that in future the expectation is that all nurses will be educated to make immediate reports at the time of incidents.

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 the zero tolerance of abuse policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee had not ensured that the results of an abuse investigation were reported to the Director. A critical incident report was submitted when the administrator became aware of alleged abuse. This report contained preliminary information regarding the investigation, however there was no further correspondence with the Director indicating the results of the investigation. The administrator confirmed that no further information had been forwarded to the Director since the original report.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



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Specifically failed to comply with the following subsections:

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. A staff person who had reasonable grounds to suspect abuse of a resident did not immediately report the suspicion and the information upon which it was based to the Director. A resident returned to the home from a leave of absence. A handwritten progress note in the resident's clinical record, written on the day the resident returned to the home, indicated the resident appeared to have sustained injuries. This information was not reported immediately. The administrator of the home became aware of the injuries two days after the resident's return and reported to the Director at that time.

[LTCHA, 2007, S.O. 2007, c.8, s.24(1)2.]

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 any person who has reasonable grounds to suspect abuse of a resident by anyone reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 30th day of November, 2011

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