Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 18, 2016	2016_251512_0003	T-3042-15	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ALTAMONT
92 ISLAND ROAD SCARBOROUGH ON M1C 2P5

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

TILDA HUI (512)

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): February 4 & 5, 2016.

This critical incident inspection is related to an allegation of physical abuse. Intake number T-3042-15/CSC 022276-15

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of care (ADOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the resident's power of attorney (POA).

During the course of the inspection, the inspector conducted observations in home and resident area, observations of care delivery processes, review the video footage, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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)**

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	Legendé 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 :

1. The licensee has failed to ensure that resident #001 was protected from abuse by staff in the home.

An identified critical incident report was received by the Ministry of Health and Long-term Care (MOHLTC) of resident #001 being physically abused by a staff member on an identified date. Review of the resident's progress notes revealed the resident complained to a staff that he/she was hit by a staff member during care resulting in pain. The resident was assessed by medical staff who noted minor injury on the identified part of the resident's body. Further record review revealed the home initiated an investigation on the alleged abuse, the police was informed, and the power of attorney (POA) of the resident was immediately contacted.

Interviews with the home's senior management staff confirmed the MOHLTC was informed of the abuse via the after hours reporting phone line at an identified time on the identified date. The Inspector viewed the home's video footage and the video revealed the resident was slapped on an identified part of his/her body by the identified PSW. The PSW was disciplined by the home. The Inspector made several attempts to contact the identified PSW and were unsuccessful.

Interviews with the home's senior management staff confirmed that the resident was not protected from abuse by a staff member in the home. [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 residents are protected from abuse by staff in the home, to be implemented voluntarily.

Issued on this 11th day of July, 2016

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

Original report signed by the inspector.