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
Direction de l'amélioration de la performance et de la conformité

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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**
November 10, 2010	2010_141_2648_08Nov155239	Complaint H-01619

Licensee/Titulaire
Vigour Ltd. Partnership on behalf of Vigour General Partner Inc.
302 Towne Centre Blvd., Suite 200, Markham, On. L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Caregiving Centre – Streetsville, 1742 Bristol Road West, Mississauga, On. L5M 1X9

Name of Inspector(s)/Nom de l'inspecteur(s)
Sharlee McNally Compliance Inspector – Nursing, #141

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection and a critical incident report submitted to the Hamilton Service Area Office
on September 23, 2010.

During the course of the inspection, the inspector spoke with: The Administrator, Assistant Director of Care and registered nursing staff

During the course of the inspection, the inspector: reviewed the resident's records, the homes investigation notes and complaint log records, and the homes policy and procedure for Incident Reporting.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect
Critical Incident Response
Reporting and Complaints
Fall Prevention

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

3 WN

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 *LTC Homes Act, 2007,* S.O 2007, c. 8, s.23(1)(a)(i)

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,

Findings:

1. The home did not complete an investigation of a reported injury to an identified resident from an incident of alleged abuse.

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WN #2: The Licensee has failed to comply with the *LTC Homes Act, 2007,* S.O 2007, c. 8, s.24(1)2

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 a risk of harm to the resident.

Findings:

1. The home did not immediately report to the Director an incident of alleged abuse to an identified resident which resulted in injury.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.103(1)

s.103(1): Every licensee of a long-term care home who receives a written complaint with respect to a

matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).
Findings: 1. The home did not submit a copy of a written complaint, related to alleged abuse to an identified resident, to the Director.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 30, 2011