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**
September 21, 22 & 24, 2010	2010_167_2570_21Sep092426	Other related to critical incident report # H-00556

Licensee/Titulaire

2063414 Ontario Limited as General partner of 2063414 Investment LP
302 Town Centre Blvd.
Suite #200
Toronto, Ontario
L3R0E8

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

Leisureworld Caregiving Centre
389 West Street,
Brantford, Ontario
N3R3V9

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

Marilyn Tone- Nursing # 167

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an other inspection related to a critical incident report.

During the course of the inspection, the inspector spoke with: The Administrator and the Director of Care for the home.

During the course of the inspection, the inspector: Conducted a review of the health file for the resident involved in the incident, a review of the home's policies and procedures related to abuse and a review of the home's investigation notes related to the incident.

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

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

[4] 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 LTCHA 2007, S.O. 2007, c.8, s.23(1)(a)(i)
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:

The licensee did not conduct an immediate investigation into the allegation of abuse.

1) A registered staff member at the home was made aware of an alleged incident of abuse that involved an identified resident on the same day that the incident occurred. The investigation was not initiated until three days later.

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WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.24(1)2
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:

The incident of suspected abuse of an identified was not reported immediately to the Director by the licensee.

1) The incident of alleged abuse involving the identified resident was not reported to the Director until three days after the incident allegedly occurred.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 104(1)2 (i,ii,iii)
104(1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

i. names of all residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

Findings:

1) The critical Incident report submitted to the Director did not include, the name of the resident involved in the incident, the name of the staff member who allegedly committed the abuse and the name of the personal support worker who reported the abuse.

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WN #4: The Licensee has failed to comply with: O.Reg.79/10 s. 97(1)(a)(b)
97(1)(a) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:

2) The Substitute Decision Maker for an identified resident was not notified of the alleged abuse involving the resident until three days after it was reported to staff at the home.

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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.** Marilyn Love
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). October 8, 2010