Ontario

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Sue McKechnie	**Inspector ID #**	140
Log #:	Log # T-504		
Inspection Report #:	2011_ 113_2633_22Mar112723		
Type of Inspection:	Critical Incident		
Date of Inspection:	March 22, 2011		
Licensee:	2063412 Ontario Limited as General Partner of 2063412 Investment LP, 302 Town Centre Blvd., Suite #200, Markham ON, L3R0R8		
LTC Home:	Leisureworld Caregiving Centre – Creedan Valley 143 Mary Street, Creemore, ON, L0M 1G0		
Name of Administrator:	Paula Rentner		

To 2063412 Ontario Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg 79/10 s. 54 (b)
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

Order:
The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds:
1. Documentation in a Resident's chart described a resident to resident abuse incident. The Home did not take any action as a result of this incident that may have prevented further incidents.
2. A further incident occurred.

This order must be complied with by:	March 22, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca

Ontario

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

prévue le *Loi de 2007 les foyers de soins de longue durée*

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Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

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55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

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1-866-311-8002

Télécopieur: 416-327-4486

☐ 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
March 22, 2011	2011_113_2633_22Mar112723	Other CI# 2633-000004-11 Log # T-504

Licensee/Titulaire
2063412 Ontario Limited as General Partner of 2063412 Investment LP,
302 Town Centre Blvd., Suite #200, Markham ON, L3R0R8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Caregiving Centre – Creedan Valley
143 Mary Street, Creemore, ON, L0M 1G0

Name of Inspector(s)/Nom de l'inspecteur(s)
Sue McKechnie - #140

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection relating to a critical incident of a resident to resident abuse.

During the course of the inspection, the inspector spoke with: The Administrator, DOC, RAI Co-ordinator, Personal Support Workers (PSW) and Registered Staff.

During the course of the inspection, the inspector: reviewed the Resident's plan of care.

The following Inspection Protocols were used in part or in whole during this inspection: Responsive Behaviours Inspection Protocol

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

[2] WN
[1] VPC
[1] CO: CO # 001

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 - **O. Reg 79/10 s. 54 (b)**
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

Findings:

1. Documentation in a Resident's chart described a resident to resident abuse incident. The Home did not take any action as a result of this incident that may have prevented further incidents.
2. A further incident occurred.

Inspector ID #:	140

Additional Required Actions:

CO # - [001] will be/was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8. s. 6 (1) (c)**
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. Incidents of aggression from an identified Resident were not written in the care plan until after a third incident occurred. There were no clear directions to staff providing care regarding the physical aggression prior to the third incident.

Inspector ID #:	140

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 that ensures the written plan of

care for each resident sets out clear directions to staff and others who provide direct care to the resident. This plan is to be implemented voluntarily.

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. Jane Saunders for Sue McKechnie
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 10, 2011

Issued on this 28th day of April, 2011.	
Signature of Inspector:	Jane Carruthers for Sue McKechnie
Name of Inspector:	Sue McKechnie
Service Area Office:	Toronto Service Area Office