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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 12, 2016	2016_377502_0002	005756-15	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ELLESMERE
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

JULIENNE NGONLOGA (502)

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): January 25 and 26, 2016.

This Critical Incident Inspection is related to a Critical Incident the home submitted on an identified date, related to the allegations of abuse to a resident.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director, Interim Director of Care, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), resident, and substitute decisions maker (SDM).

The inspector observed the provision of care, staff to resident interactions; reviewed resident's health records, staffing schedules, training records, staff employment records, home's record and relevant policies and procedures

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.
- **2 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 residents are protected from abuse by anyone in the home.

In accordance with the definition identified in subsection 2 (1) of the Act, physical abuse includes the use of physical force by anyone other than a resident that causes physical injury or pain.

The Ministry of Health received a Critical Incident Report on a specific date from the home alleging staff members witnessed physical abuse of a resident by another staff.

Review of the home's internal investigation file revealed on a specific date and time, when staff #101, staff #106, and staff #107 were redirecting resident #001 from the nursing station to his/her room, the resident indicated to staff #101 that the staff member was hurting him/her. When the above identified staff members and the resident entered the resident's room, staff #101 slapped resident #001 across his/her face. Further review of the home's internal investigation revealed that a letter containing a signed statement from staff #106 and #107 was received by staff #100 alleging staff #101 physically abused resident #001.

Interview conducted with staff #101, indicated resident #001 was resistive while being redirected to his/her room on a specific date and time. Staff #101 further stated he/she was encouraging the resident to go back to sleep in his/her bed, and denied slapping resident #101 across his/her face.

Interviews conducted with staff #106 and #107 confirmed the resident indicated to staff #101 that the staff member was hurting him/her; resident #001 became agitated, and staff #101 raised his/her voice, and started swearing at the resident in an identified language. Staff #106 and #107, who understand the language confirmed they did not stop staff #101 at that moment. When they reached the resident's bedroom, staff #101 slapped resident #001 across his/her face and started pulling the resident by his/her clothes in a rough manner toward the bed, at that moment staff #107 intervened by by telling staff #010 to stop and staff #101 stopped. Staff #106 and #107 confirmed the incident was not reported to the nursing staff during the shift and staff #101 continued his/her assignment by taking care of resident #001 to the end of the shift.

Interview conducted with management staff #136 confirmed the above incident occurred and that resident #001 was not protected from abuse. The management staff indicated all staff involved in the incident was disciplined. He/she further stated that staff #101 had stopped providing care to resident #001. [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 anyone in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred must immediately report the suspicion and the information upon which it is based to the Director.

Record review of the home's internal investigation file which included a signed statement from two staff who witnessed the physical abuse of resident #001 was conducted. It was revealed that this alleged physical abuse occurred on a specific date and time. The Director was not notified of the incident until a day after.

Interviews conducted with staff #106 and staff #107 confirmed they were assisting staff #101 when he/she slapped resident #001 across his/her face on a specific date and time. Staff #106 and Staff #107 confirmed they did not report the incident to the Director as required under the Long- Term Care Home (LTCH) Act until the next identified shift.

Interview conducted with staff #100 revealed he/she received a letter from staff #106 on a specific date and time. The letter described the above mentioned alleged abuse, which he/she did not immediately report to the Director as required under the LTCH Act.

Interview with management staff #136 confirmed the alleged abuse was witnessed by two staff members, the charge nurse became aware of the incident on a specific date, however the incident was not reported to the Director as required under the LTCH Act until a specific date, one day after the alleged abuse occurred. [s. 24. (1)]

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.