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
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Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 30, 2010	2010_105_2628_29Sep141758	Mandatory Report L-01204

Licensee/Titulaire
Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd. Suite 200 Toronto ON L3R0E8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Caregiving Centre-Oxford 263 Wonham St.S. Ingersoll, ON N5C 3P6

Name of Inspector/Nom de l'inspecteur(s)
June Osborn #105

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Mandatory Report inspection related to resident abuse.

During the course of the inspection, the inspector spoke with the administrator.

During the course of the inspection, the inspector had the administrator state the status of the investigation, answer questions about the CI report that was submitted, obtained a copy of the Resident Abuse Policy, administrator took the inspector around to meet 4 of the residents involved the others were isolated due to illness.

The following Inspection Protocols were used in part or in whole during this inspection: Prevention of Abuse and Neglect

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

2WN
2 VPC

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.97(1) (b)
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,
(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:
1. At the beginning of this inspection September 30, 2010 no substitute decision-makers had been notified of the alleged abuse against any of the seven residents. The incidents were reported to the administrator September 21, and 22, 2010.

Inspector ID #:	105

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 with O. Reg. 79/10 s.97(1)(b), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg. 79/10 s.8(1)(b)
Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(b) is complied with.

Findings:

1. Policy with Subject Title: Abuse-Resident. Policy Identifier: V3-010 under procedure #9 states: "Inform the family or POA(personal care) of the alleged abuse, and assure them of the resident's safety. Advise the resident's representative that the investigation will be carried out immediately, and communication with them will remain open. This was not done in any of the seven identified cases of alleged abuse at the start of this inspection September 30, 2010. The incidents were reported to the administrator September 21 and 22, 2010.

Inspector ID #:	105

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 O. Reg. 79/10 s.8(1)(b), 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.**
Title: **Date:**	**Date of Report: October 8, 2010**