

Ministry of Health and Lorg-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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch 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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 13, 14, 30, Apr 4, 2012	2012_021111_0005	Critical Incident
Licensee/Titulaire de permis		
VIGOUR LIMITED PARTNERSHIP O 302 Town Centre Blvd, Suite #200, M	ARKHAM, ON, L3R-0E8	
Long-Term Care Home/Foyer de so	ins de longue durée	
LEISUREWORLD CAREGIVING CEN 3015 LAWRENCE AVENUE EAST, S		
Name of Inspector(s)/Nom de l'insp	ecteur ou des inspecteurs	
LYNDA BROWN (111)		
	nspection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), one Registered Nurse (RN), one Registered Practical Nurse(RPN) and one Personal Support Worker (PSW).

During the course of the inspection, the inspector(s) observed the resident, reviewed the residents health records and reviewed of the homes records

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Homes Act, 2007 (LTCHA) was found. (A requirement under the	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants:

1.An identified resident requiring pain management, did not have the plan of care complied with as specified in the plan, resulting in pain.

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 subsections:

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

Findings/Faits saillants:

1. An alleged incident of staff to resident abuse/neglect was reported to the home and the incident was not reported to the Director immediately.



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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 any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training Specifically failed to comply with the following subsections:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants:

1. The licensee failed to ensure that all staff at the home have received re-training on Abuse Prevention & Resident Rights annually.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants:

1. An alleged incident of staff to resident abuse/neglect was reported to the home. When the home confirmed the incident of resident abuse/neglect had occurred, the police were not notified.

Issued on this 13th day of April, 2012

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

Brown.