



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

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**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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 5, 2014	2014_298557_0006	T-667-13	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 - VAUGHAN

5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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

VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): April 22, 23, 25 and May 5, 2014.

During the course of the inspection, the inspector(s) spoke with the director of administration, director of care, associate director of care, nurse manager, registered nursing staff, personal support workers, behavioural support nurse, residents and substitute decision-makers.

During the course of the inspection, the inspector(s) conducted observations of the home area, a tour of the facility, reviewed resident records, reviewed home's policies and procedures, observed staff and resident interactions, and resident to resident interactions.

**The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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
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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) 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. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee failed to ensure that the resident's substitute decision-maker was notified immediately upon becoming aware of a witnessed incident of abuse of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Record review revealed that on an identified date, an incident took place between resident #001 and resident #004. Resident #004 was punched and slapped in the face by resident #001. Registered nursing staff intervened and assessed resident #004 for injuries. An incident report was completed by the registered nursing staff and the staff member did not contact the substitute decision maker of resident #004 to notify them that an incident had occurred.

Record review and staff interviews confirmed that resident #004's substitute decision-maker was not notified after the witnessed incident of abuse.



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Issued on this 11th day of June, 2014

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