



**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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<input type="checkbox"/> Licensee Copy/Copie du Titulaire <input checked="" type="checkbox"/> Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection January 24, 2011	Inspection No/ d'inspection 2011_125_9510_24Jan100842	Type of Inspection/Genre d'inspection CIS Follow-up Log # T-061
Licensee/Titulaire Toronto Long-Term Care Homes and Services, 55 John Street, Toronto, ON M5V 3C6		
Long-Term Care Home/Foyer de soins de longue durée Castlevue Wychwood Towers, 351 Christie Street, Toronto, ON M6G 3C3		
Name of Inspector/Nom de l'inspecteur Marsha Hardwick # 125		
Inspection Summary/Sommaire d'inspection		

The purpose of this inspection was to conduct a follow-up to two CIS reports regarding alleged staff to resident abuse.

During the course of the inspection, the inspector spoke with:

- Administrator
- Director of Care
- Head Nurse
- Personal Care Aides
- Registered staff

During the course of the inspection, the inspector:

- Review of Resident's health record
- Inspected Resident's room
- Reviewed Policies: Residents' Bill of Rights; Zero Tolerance for Abuse and Neglect; Resident Abuse and Neglect: Investigation and Reporting & Education and Awareness on Prevention of Resident Abuse.

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

- Prevention of Abuse and Neglect Inspection Protocol

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

[2] WN

[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 the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.24 (1) 2.

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:

2. 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.

Findings:

- **The licensee did not immediately report to the Director a critical incident regarding abuse.**

Inspector ID #: 125

VPC - Pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.24 (1) 2. The licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that abuse by anyone shall immediately be reported to the Director.

WN #2: The Licensee has failed to comply with the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.23 (1) (a) (i).

23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone.

Findings:

The licensee did not immediately investigate abuse.



Inspector ID #: 125	
VPC - Pursuant to the <i>Long-Term Care Homes Act, 2007</i> , S.O. 2007, c.8, s.23 (1) (a) (i). The licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every incident of abuse is immediately investigated.	

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: _____	<i>Quint 3/2011 M. H. ...</i> Date of Report: (if different from date(s) of inspection).