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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
October 27 and 29, 2010	2010_147_2472_29Oct141625	Critcal Incident – H-01877 and H-01888

Licensee/Titulaire
Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd.
Suite #200
Markham, ON
L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Mississauga
2250 Hurontario Street
Mississauga, ON
L5B 1M8

Name of Inspector

Laleh Newell - 147

Inspection Summary/Sommaire d'inspection

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

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

Director of Care, Administrator and staff on the unit.

During the course of the inspection, the inspector:

Reviewed resident's clinical chart, reviewed home's policy and procedure related to Resident Abuse, reviewed internal incident and investigation reports, observed care, toured the home and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse and Neglect

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

[3] WN
[3]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.	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-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.)	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. 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. Two incidents of verbal and physical abuse occurred by an Registered Practical Nurse towards two identified residents in 2010. These incidents were witnessed by the staff on the unit and by the nursing student who reported the incidences in writing to the Director of Care in 2010.
2. According to the home's Abuse-Resident – V3-010 policy, the charge nurse is to check resident's condition to assess the safety, emotional and physical well being and to immediately sought medical attention if required.
3. The documentation in the progress notes for both residents do not support that a comprehensive assessment was conducted by the charge nurse as per home's policy and procedure to ensure the safety, emotional and physical well being of the residents were assessed and if any immediate medical attention was required.
4. The Registered Practical Nurse did not complete an incident report for either of the incidences as per home's policy and procedure and instructed the nursing student not to report these incidences either.

Inspector ID #:	147

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 all staff comply with the policy and procedure of the home related to Resident Abuse, to be implemented voluntarily.

WN #2 The Licensee has failed to comply with – LTCHA, 2007, S.O. 2007, c. 3(1)(2)
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse.

Findings:

1. Two incidents of verbal and physical abuse occurred by Registered Practical Nurse (RPN) towards two identified residents in 2010. These incidents were witnessed by the staff on the unit and by the nursing student who reported the incidences in writing to the Director of Care, in 2010.
2. According to the nursing student's written statement regarding one of the incidents in 2010, an identified resident demonstrated responsive behaviours and the RPN responded inappropriately verbally and physically. According the nursing student's observations documented in the written statement, the incident resulted in the resident becoming more emotional and distressed.
3. According to the nursing student's written statement regarding the second incident in 2010, an identified resident was following the RPN down the hallway, which annoyed the RPN, the RPN turned around and responded inappropriately, verbally and physically, to the resident.
4. The home conducted a full investigation in 2010 and verified all the allegations. The home responded to these incidences.

Inspector ID #:	147

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 all residents are have the right to be protected from abuse, to be implemented voluntarily.

WN # 3: 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.

Findings:

1. Two witnessed incidences of physical and verbal abuse of two resident that occurred by the home's RPN were not immediately reported to the police when the home became aware of the situation in 2010.

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 all to meet the requirement that any alleged, suspected or witnessed abuse of a resident is immediately reported to the police, 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. Aug 30/11 Revised August 30, 2011 for the purpose of publication
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).