Ontario

Inspection Report under the *Licensees 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

Toronto Service Area Office
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Toronto ON M4V 2Y7

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55, avenue St. Clair Ouest, 8ième étage
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☐ 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
March 3, 4, 8, 11, 2011	2011_162_922_03Mar094052	Complaint T-034

Licensee/Titulaire
Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd, Suite 200
Fax 905-489-0790

Licensee/Foyer de soins de longue durée
Leisureworld Caregiving Centre - Cheltenham
5935 Bathurst Street, North York, ON M2R 1Y8
Fax 416-223-4159

Name of Inspector(s)/Nom de l'inspecteur(s)
Tiina Tralman (162)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding abuse.

During the course of the inspection, the inspectors spoke with: Director of Care (DOC), Assistant Director of Care (ADOC), Program Manager, Social Worker, Food Service Manager, main (first), second and third floor Registered Nursing Staff, Personal Support Workers and Family. Telephone interviews were conducted with Registered Nursing staff, student PSW.

During the course of the inspection, the inspector:

- Conducted a walk through of resident home areas and common areas
- Reviewed health care record
- Reviewed the home's Abuse Prevention Program and policies and procedures

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:

6 WN
4 VPC
CO: CO #001

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 *Licensees 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 LTCHA, 2007 S.O. 2007 c. 8 s. (2) 3. 4. Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The licensee's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.

Findings:

1. A resident was physically abused by a staff member.
2. The abuse incident was not immediately reported to the Director.
3. A staff member who was aware of the abuse incident did not have training on the licensee's policy to promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports prior to performing his/her responsibilities.
4. A staff member who was aware of the abuse incident did not report the abuse incident after receiving training on the licensee's policy promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports.
5. The staff member who physically abused a resident did not receive training on the licensee's policy to promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports prior to performing his/her responsibilities.

Inspector ID #:	162

Additional Required Actions:

CO # - 001- will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 79 (1) (3) (c), (p);
(1) Every licensee of a licensee shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.
(3) The required information for the purposes of subsections (1) and (2) is, (c) is, the licensee's policy to promote zero tolerance of abuse and neglect of residents; (p) an explanation of the protections afforded under section 26;

Findings:

1. The following required information was not posted in the home.
   - The licensee's policy to promote zero tolerance of abuse and neglect of residents.
   - An explanation of whistle-blowing protections related to retaliation under section 26.
2. The licensee's policy to promote zero tolerance of abuse and neglect of residents and an explanation of whistle-blowing protections related to retaliation under section 26 were posted in the home on March 8, 2011.

Inspector ID #:	162

WN # 3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 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. A resident was physically abused by a staff member.
2. The staff member who physically abused a resident told the witness not to tell anyone.

Inspector ID #:	162

Additional Required Actions:

VPC - pursuant to the *Licensees 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 every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 24. (2) 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 a risk of harm to the resident.

Findings:

1. A resident was physically abused by a staff member.
2. The abuse was witnessed but was not reported immediately to the Director.
3. A staff member who was aware of the suspected abuse incident did not immediately report the suspicion and the information upon which it is based to the Director.

Inspector ID #:	162

Additional Required Actions:

VPC - pursuant to the *Licensees 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 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: 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s 20. (2) (d) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

Findings:

1. The licensee's written policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. The written policy does not reference duty under section 24 of the Act to make mandatory reports.

Inspector ID #:	162

Additional Required Actions:

VPC - pursuant to the *Licensees 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 the licensee's written policy contains an explanation of the duty under section 24 of the Act to make mandatory reports.

WN #6: The Licensee has failed to comply with O. Reg 79/10, s.96 (e)(ii) Every licensee of a licensee shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(e) identifies the training and retraining requirements for all staff, including,
(ii) situations that may lead to abuse and neglect and how to avoid such situations.

Findings:

1. The licensee's written policy does not identify the training and retraining requirements for all staff including:
   (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

Inspector ID #:	162

Additional Required Actions:

VPC - pursuant to the *Licensees 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 the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(e) identifies the training and retraining requirements for all staff, including,
(ii) situations that may lead to abuse and neglect and how to avoid such situations, 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.** Jina Walman
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 22 2011

Ontario

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Tiina Tralman	**Inspector ID #**	162
Log #:	T-034		
Inspection Report #:	2011_162_922_03Mar094052		
Type of Inspection:	Complaint		
Date of Inspection:	March 3, 4, 8, 11, 2011		
Licensee:	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 200 Fax 905-477-4006		
LTC Home:	Leisureworld Caregiving Centre – Cheltenham 5935 Bathurst Street, North York, ON M2R 1Y8 Fax 416-223-4159		
Name of Administrator:	Lora Palmer, Acting Director of Administration		

To Vigour Partnership Limited, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: LTCHA 2007, S.O. 2007, c.8, s. 76. (2) 3. 4. Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The licensee's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.

IO – 08/12 4:20 pm

Order:

The licensee shall prepare and submit a written plan by Tuesday, April 5, 2011 for achieving compliance to meet the requirement that all staff receive training on the licensee's policy to promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports.
This plan shall be implemented.
The plan is to be submitted to Inspector: Tiina Tralman, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 55 St. Clair Avenue West, Toronto, ON M4V 2Y7
Fax 416-327-4486.

Grounds:

1. A resident was physically abused by a staff member.
2. The abuse incident was witnessed but not immediately reported to the Director.
3. A staff member who was aware of the incident did not receive training on the licensee's policy to promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports prior to performing his/her responsibilities.
4. A staff member who was aware of the abuse incident did not report the abuse incident after receiving training on the licensee's policy promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports.
5. The staff member who physically abused a resident did not receive training on the licensee's policy to promote zero tolerance of abuse and neglect of residents and duty under section 24 to make mandatory reports prior to performing his/her responsibilities.

This order must be complied with by:	April 19, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk

Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 22nd day of March, 2011.	
Signature of Inspector:	Tiina Tralman
Name of Inspector:	Tiina Tralman
Service Area Office:	Toronto Service Area Office