Ministry of Health and Long-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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Apr 8, 2014	2014_266527_0008	H-000258-13 & H-000834-13	Critical Incident System

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - STREETSVILLE
1742 BRISTOL ROAD WEST, MISSISSAUGA, ON, L5M-1X9

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

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 2, 2014.

The inspection conducted was related to two Critical Incidents, Log #: H-000834-13 and H-000258-13. The critical incidents were related to a resident fall and transferring of a resident, both resulting in significant injuries.

During the course of the inspection, the inspector(s) spoke with the resident, the resident's family or Power of Attorney, Personal Support Workers, Registered Nursing Staff, the Assistant Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed resident and staff interactions; observed resident transfers; interviewed the resident; interviewed one of the resident's family/Power of Attorney; interviewed staff; and reviewed health records; policies and procedures; and training/educational records and programs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. The licensee did not ensure the care set out in the plan of care is provided to the resident as specified in the plan.

a) In reviewing the current plan of care for the resident, it identifies the resident requires a two person transfer, the arm is to be elevated with pillows and maintain body alignment. The resident can assist with feeding and activities of daily living (ADLs).
b) The resident was observed in bed and staff stated the resident has not been out of bed since last week. The resident was misaligned and laying diagonally across the bed. The resident had no pillows under the arm and hand.
c) The Personal Support Workers (PSW) confirmed the resident's care has changed and the resident is now bedridden, is repositioned every two hours in bed, and is totally dependent on staff for activities of daily living.
d) The registered staff confirmed the resident's condition has deteriorated, the interventions have changed and the written plan of care was not revised.
e) The Assistant Director of Care confirmed the resident is now palliative and the plan of care has not been revised.

The resident has had a significant change in their condition and the written plan of care has not been revised to ensure the care provided to the resident is as specified in the plan. [s. 6. (7)]

Issued on this 12th day of April, 2014

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