Ontario

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
Nov 7, 2013	2013_031194_0041	000573,000601,000041,000020-13	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 - ELLESMERE
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

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

CHANTAL LAFRENIERE (194)

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): September 22, 24 & 25, 2013

During the course of this inspection five critical inspection logs were reviewed, Log # 000573-13,000041-13,000020-13,000601-13 and 001016-13

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Assistant Director of Care(ADOC), Social Worker (SW),Registered Nurses (RN), Personal Support Worker (PSW), three Residents

During the course of the inspection, the inspector(s) reviewed clinical health records for seven Residents, BSO(Behavioural Support Ontario)documentation, Six Critical Incident Reports,observed staff/resident provision of care.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007,s.6(1)(c) when the written plan of care for resident #4 did not set out clear direction to staff and other who provide direct care, related to the resident's unpredictable and aggressive behaviour.

A critical incident report was submitted to MOHLTC reporting a resident to resident altercation. The report states resident #4 was suddenly aggressive towards another co -resident. When staff asked resident #4 why this was done, the resident replied because the co-resident was in the way.

The progress notes for resident # 4 were reviewed;
-on an identified date resident #4 was observed by staff being aggressive towards a co-resident.
-on another identified date, resident #4 is observed by staff "aggressively" pulling at a chair that a staff member was sitting in, stating "get out of my chair, it's my chair".

The Administrator, Social Worker and ADOC were interviewed and confirmed that resident #4 was cognizant and demonstrated unpredictable aggressive behaviours. Staff interviewed stated that resident #4 was territorial of their personal space.

The written plan of care for resident #4 does not set out clear direction to staff related to the resident's unpredictable or territorial behaviour. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 107(1)2 when the Director was not notified immediately of an unexpected death.

Resident #7 deceased at the home unexpectedly, the Director was notified of the death, 7 days later.

Issued on this 7th day of November, 2013

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

Chantal Lafreniere (194)