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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2015	2015_378116_0021	008050-15	Complaint

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 - ETOBICOKE
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 5, 6, 9, 10, 12, 13, 2015.

During this inspection the inspector reviewed relevant home records, relevant policies and procedures, complaints binder, training records, Family Council minutes and observed staff to resident interactions throughout the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Associate Director of Care (ADOC), Family Council President, registered staff members, physiotherapist, physiotherapist assistant and personal support workers (PSW).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, resident #001 was observed to have an injury of unknown cause. As per the management of the home, a change in the planned interventions regarding transfers of the resident was verbally communicated to staff.

On an identified date, an identified individual witnessed staff members #105 and #107 transfer resident #001. Interviews held with staff #105 and #107 confirmed that they were made aware at the beginning of the shift of the change in interventions for resident #001 however, they misunderstood.

The written plan of care was revised after the incorrect transfer, to include the intervention. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and appropriate clean footwear.

The written plan of care for resident #001 indicates that the resident is totally dependent on staff for dressing and requires two person assistance.

A review of resident #001's health record and the home's complaint binder revealed that on an identified date, resident #001 was observed to be dressed inappropriately. A specified garment was not fully applied to the resident. Review of the complaint record revealed and interviews held with staff members #100 and #106 confirmed that staff #104 did not complete the task of fully dressing resident #001. Further interviews held with the ADOC confirmed that resident #001 was not dressed appropriately and to his/her preference on the identified date. [s. 40.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The written plan of care for resident #001 identifies that the resident has skin integrity issues. The resident sustained an injury to an identified area of unknown etiology on an identified date.

On an identified date, the physician ordered a specified treatment for the identified injury. A review of the health record for resident #001 revealed that on an identified date, staff #101 provided a treatment to the identified injury. An interview held with staff #001 confirmed that the incorrect treatment was applied as the prescribed dressing was unavailable. Interviews held with staff #101 and the ADOC confirmed that the supplies were not readily available. [s. 50. (2) (c)]

Issued on this 7th day of December, 2015

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

Original report signed by the inspector.