



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

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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
May 2, 2014	2014_336580_0005	S-000100-14	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 - NORTH BAY
401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5

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

VALA MONESTIMEBELTER (580)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): April 24 and 25, 2014.

This inspection is in relation to Log #S-000100-14.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, observed staff to resident interactions, the provision of care to residents including meal services, reviewed two residents' health care records and various policies.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) 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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector 580 reviewed Critical Incident (CI) Report involving an alleged resident to resident abuse. The CI Report identifies Resident #101, who has a history of wandering, attempting to enter the room of Resident #103 where there was a yellow strip of material placed across the doorway to deter residents who wander from entering. When Resident #102 (who was visiting Resident #103) noticed Resident #101 attempting to enter through the doorway, Resident #102 approached Resident #101 and pushed the resident, resulting in a fall. This incident was witnessed by the Registered Practical Nurse (RPN) on shift. Inspector 580 interviewed the Director of Care (DOC) who confirmed the details of the CI Report.

The Licensee did not ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be protected from abuse. [s. 3. (1) 2.]

Issued on this 2nd day of May, 2014

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