Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Aug 9, 10, 28, 29, 31, Sep 4, 5, 10, 2012	2012_080189_0025	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 - RICHMOND HILL
170 Red Maple Road, RICHMOND HILL, ON, L4B-4T8

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Acting Director of Administration, Assistant Director of Care, Registered Staff, Personal Support Workers

During the course of the inspection, the inspector(s) Reviewed Health Care Records Reviewed the homes Lift and Transfer Policy

The following Inspection Protocols were used during this inspection:

Personal Support Services

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 subsections:

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. Resident did not receive the required care as indicated in resident's care plan.

Plan of care for resident indicates the following: TRANSFERS: Two person physical assistance, Mechanical Lift use for transfers. Extensive assistance in weight bearing, requires physical help.

Plan of care for resident indicates the following: TOILETING: Resident should never be left unattended on the toilet.

On August 2, 2012, Personal Support Worker transferred the resident from wheelchair to toilet without a second person assisting and without the use of a mechanical lift.

PSW reported to the inspector that on August 2, 2012, after lunch, PSW wheeled the resident into the washroom, asked the resident to stand up by self by grabbing the bar in the washroom, and PSW assisted the resident onto the toilet. PSW then placed the resident's wheelchair in front of the resident, locked the wheelchair and told the resident not to move.

PSW reported to the inspector that he/she then left the room to put the dirty linen away, while placing the linen away he/she was called by another resident who was requesting assistance. PSW went to assist the resident and then returned back to the resident's room where he/she found the resident on the floor, lying on the right side in a small pool of blood. Registered Staff and other PSW's attended to the resident who was immediately transferred to the hospital.

Care plan notes resident inability to weigh bear. Registered Staff and Personal Support Workers (PSW) informed inspector that resident is mostly wheelchair bound with limited mobility. Inspector observed on August 9th, 2012 two person transfer with mechanical lift logo located above the resident's bed.

PSW reported to the inspector on August 10, 2012 that he/she did not use a mechanical lift to transfer the resident to the toilet and he/she did not call a second person for assistance. PSW also reported to the inspector that he/she did not refer to the plan of care prior to providing care for the resident to ensure that he/she was providing the appropriate care for the resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes 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 all staff follow direction regarding transfers as outlined in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Plan of care for resident indicates the following: TRANSFERS: Two person physical assistance, Mechanical Lift use for transfers. Extensive assistance in weight bearing, requires physical help.

Plan of care for resident indicates the following: TOLIETING: Resident should never be left unattended on the toilet.

On August 2, 2012, Personal Support Worker transferred the resident from wheelchair to toilet without a second person assisting and without the use of a mechanical lift.

PSW reported to the inspector that on August 2, 2012, after lunch, PSW wheeled the resident into the washroom, asked the resident to stand up by self by grabbing the bar in the washroom, and PSW assisted the resident onto the toilet. PSW then placed the resident's wheelchair in front of the resident, locked the wheelchair and told the resident not to move.

PSW reported to the inspector that he/she then left the room to put the dirty linen away, while placing the linen away he/she was called by another resident who was requesting assistance. PSW went to assist the resident and then returned back to the resident's room where he/she found the resident on the floor, lying on the right side in a small pool of blood. Registered Staff and other PSW's attended to the resident who was immediately transferred to the hospital.

Resident had sustained a un-witnessed fall, resulting in serious injury.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes 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 that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 10th day of September, 2012

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

Nicole Ramp