



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 23, 24, 29, Dec 1, 6, 9, 13, 2011	2011_108110_0010	Critical Incident

**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 - VAUGHAN  
 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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

DIANE BROWN (110)

**Inspection Summary/Résumé de l'inspection**

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, registered nurses, personal support worker, registered dietitian, dietary aide.

During the course of the inspection, the inspector(s) Completed a review of an identified resident care record.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

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



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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Interventions identified in a resident's plan of care were not practiced. The identified resident had risks described in his/her plan of care that were not known to staff providing care.

**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 subsections:**

**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):**

**1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.**

**2. An unexpected or sudden death, including a death resulting from an accident or suicide.**

**3. A resident who is missing for three hours or more.**

**4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.**

**5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.**

**6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee did not immediately inform the Director of an unexpected death of a resident resulting from an accident. The unexpected death was reported eleven(11)days after the date of the incident.

Issued on this 13th day of December, 2011



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

*Diane Brown*