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
Dec 31, 2012	2012_174189_0014	T-922-12, T-1004-12	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 - VAUGHAN
5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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.

This inspection was conducted on the following date(s): December 13, 14, 2012

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

During the course of the inspection, the inspector(s) Reviewed health care records

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 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 failed to ensure that the care set out in the plan of care is provided to resident #1 as specified in the plan.

Plan of care for resident #1 states resident is High Risk for falls, staff to ensure posey alarm is always attached to the resident and staff to visually monitor resident. Resident #1 is totally dependent for transfers and requires two person physical assistance.

On April 24, 2012, a Personal Support Worker (PSW) transferred the resident from bed to wooden chair and left the resident unattended in the room. The resident did not have a posey alarm in place. The resident fell from the chair and sustained a fractured hip.

Staff interviews confirmed that the resident is wheelchair bound with a history of falls and that the resident was not to be left unattended. Staff interview also confirms that an identified PSW #1 transferred the resident from bed to wooden chair without a second person assisting. [s. 6. (7)]

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. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Plan of care for resident #1 states resident is high risk for falls; staff to ensure posey alarm is always attached to the resident and staff to visually monitor resident. Resident #1 is totally dependent for transfers and requires two person physical assistance.

On April 24, 2012, PSW #1 transferred the resident from bed to wooden chair without a second person assisting and left the resident unattended in the room. Resident fell from the chair and sustained a fractured hip as a result of the fall.

PSW #2 informed inspector that on April 24, 2012, while he/she was doing rounds, he/she went into the resident's room and found the resident sitting on a wooden chair. PSW #2 then went to seek assistance from staff, however the home's fire alarm system was activated. After attending to the fire alarm, PSW #2 stated that he/she and PSW #3 returned to the resident's room where they found the resident on the floor bleeding from his/her forehead.

Staff interviews confirmed that an identified PSW #1 transferred the resident from bed to wooden chair without a second person assisting and left the resident unattended. [s. 36.]

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 and positioning devices or techniques when assisting residents, to be implemented voluntarily.

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Issued on this 22nd day of January, 2013

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