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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Jul 12, 2013	2013_163189_0017	T-111-13, T-285-13	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 - 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

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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): June 11, June 13, June 17, June 24, June 26, July 3, 2013

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

During the course of the inspection, the inspector(s) Reviewed health care records, conducted a tour of resident and common areas

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.)	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 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.

Resident # 5 is totally dependent for transfers and requires two person physical assistance with mechanical lift.

Personal Support Worker (PSW) #1 reported to the inspector that on January 16, 2013, after lunch, he/she wheeled the resident to his/her room to put the resident back to bed. PSW #1 called PSW #2 to assist with the transfer. PSW #1 placed the transfer sling underneath the resident and proceeded to use the hoyer machine to mechanically lift the resident out of the wheelchair. PSW #1 reported that while in the sling, the resident slid down halfway and was not correctly positioned in the sling.

PSW #1 reported that he/she was having difficulty manoeuvring the hoyer lift to position the resident over the bed. PSW #2 was at the resident's beside awaiting to assist the resident into the bed. PSW #1 reported that as he/she was trying to position the resident over the bed, he/she moved the hoyer lift back and forth against the bed and the resident hit his/her head against the bedside rail, and the resident sustained a injury to the head.

During interview with the inspector, PSW #1 and PSW #2 reported that they did not know that the bedside rails are required to be down in order to make the way clear when transferring the resident with the hoyer lift into the bed. PSW #1 also reported to the inspector that he/she did not receive training on lifts and transfers prior to performing his/her responsibilities.

PSW #1 did not ensure that the resident was positioned correctly in the sling and did not use safe positioning techniques when assisting resident # 5. [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 techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home receive training as required prior to performing their responsibilities.

PSW #1 reported to the inspector that he/she was hired in May 2012 and did not receive training on the following during orientation or prior to performing his/her responsibilities:

1. The long-term care home's mission statement
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
3 The duty under section 24 to make mandatory reports
4. The protection afforded by section 26
5. Infection prevention and control
6. Lifts and transfers [s. 76. (2)]

2. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the area set out in s. 76(7) and O.Reg. 79/10 s .221. (1)

PSW #1 reported to the inspector that he/she did not receive training on the following areas during orientation or prior to performing his/her responsibilities:

1. Abuse recognition and prevention
2. Fall prevention and management
3. Skin and wound care

Director of Care confirmed to the inspector that PSW #1 did not receive training on the above requirements. [s. 76. (7) 6.]

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 all staff at the home have received training as required by section 76 of the LTCHA, 2007, to be implemented voluntarily.

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Issued on this 15th day of July, 2013

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