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
Jul 11, 2013	2013_163189_0015	T-135-13	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): June 7, June 10, June 11, June 12, June 13, 2013

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

During the course of the inspection, the inspector(s) Conducted a tour of resident and common areas, 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.

Progress notes and staff interviews indicate that on March 6, 2013, resident complained of pain to his/her right leg. Registered staff assessed resident's right leg to be swollen and warm to touch. Resident was assessed by the Nurse Practioner (NP) on March 7, 2013, and NP ordered "STAT doppler ultrasound of the right leg and x-ray of the right knee joint".

Registered staff reported to the inspector that on evening of March 8, 2013, he/she contacted the ultrasound department and was informed that the ultrasound and x-ray will not be completed until March 11, 2013. Registered staff reported that he/she contacted the charge nurse to request that the resident be sent to the hospital to have the ultrasound and x-ray taken. Registered staff reported that he/she was instructed by the charge nurse to wait until March 11, 2013 to have the ultrasound and x-ray taken. Registered staff reported that as per policy, if the resident is unable to receive the immediate ultrasound or x-ray in the home, the physician and family should be notified and the resident should be sent to hospital for further testing. This policy was also confirmed by the Director of Care and Assistant Director of Care upon interview by the inspector. The resident was not sent to the hospital as per his/her plan of care.

Resident #1 did not receive the ultrasound and x-ray until March 11, 2013. X-ray results revealed resident sustained an undisplaced fracture to his/her right leg. The resident was sent to hospital on March 13, 2013 and returned to the home with a leg cast on March 14, 2013. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report: (4) An injury in respect of which a person is taken to hospital.

On March 7, 2013, resident #1 was assessed by the Nurse Practitioner and ordered to have STAT ultrasound and x-ray taken after complaints of pain and swollen right leg. The x-ray was not taken until March 11, 2013. X- ray results revealed resident sustained an undisplaced fracture to his/her right leg. The resident was sent to hospital on March 13, 2013 and returned to the home with a leg cast on March 14, 2013.

The Ministry of Health and Long Term Care Director was not notified of the resident's transfer to hospital. [s. 107. (3) 4.]

Issued on this 15th day of July, 2013

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