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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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 2, 5, 6, 7, 19, 20, 2011	2011_083178_0024	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 - LAWRENCE
2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4

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

SUSAN LUI (178)

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 Director of Administration, Director of Care (DOC), registered staff, personal support workers (PSWs), and a resident.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home policies and protocols, reviewed home training records, observed resident care.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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. Licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

a)An identified PSW transferred an identified resident without the assistance of a second person, as directed in the home's Lifting Devices-Mechanical policy and in the resident's plan of care. The PSW also repositioned the resident in bed without any assistance. As a result, the resident sustained a serious injury, and required admission to hospital. The home has suspended the PSW involved while investigating the incident, and plans to issue discipline.

b)The inspector was informed by two different identified staff members that they have conducted mechanical lifts while the second person assisting does so by observing from the door of the room, rather than assisting at the resident's side.

c)The home's Lifting Devices-Mechanical policy states that education shall be provided to employees on safe lifts/transfers/repositioning including use of mechanical lifts, at orientation. The policy states that this education shall be provided by the person best suited to provide the training, i.e. equipment distributor, Director of Care or designate, educator, physiotherapy staff.
The policy also states that management and registered staff shall monitor the safe resident lifts/transfers/repositioning program to ensure that the respective policies, procedures and protocols are carried out.
An identified Registered Nurse (RN), was not provided safe lifts/transfer education on orientation. The RN was hired over four months ago, and at the time of this inspection has not received training on safe lifts/transfers, although as a registered staff member the RN is responsible for monitoring the program to ensure that the policies and protocols are carried out.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. Care for an identified resident was not provided to the resident as specified in the plan.
The plan of care for the identified resident states that the resident is to be lifted mechanically and requires "two plus persons physical assist" for transfers and bed mobility. On a specific date the resident was transferred from wheelchair to bed by an identified PSW alone, using a mechanical lift. The PSW also repositioned the resident in bed without assistance. As a result, the resident sustained a serious injury, and required admission to hospital.

The Licensee has suspended the PSW involved.

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 for an identified resident's transferring and bed mobility needs is provided as specified in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The home has failed to ensure that it's Lifting Devices-Mechanical ("Minimal Lift/Zero Lift Policy"), #V3-850 is complied with.

a)The home's Lifting Devices-Mechanical policy states that during a mechanical lift one caregiver operates the lift while the second caregiver guides the resident in the sling.
The inspector was informed by two different identified staff members that they have conducted mechanical lifts while the second person assisting does so by observing from the door of the room, rather than assisting at the resident's side.

b)The home's Lifting Devices-Mechanical ("Minimal Lift/Zero Lift Policy"), # V3-850 states that at least two caregivers shall be present from the beginning to the end of the lift, with one caregiver operating the lift and the other caregiver guiding the resident in the sling.
An identified PSW transferred an identified resident from bed to chair using a mechanical lift alone, with no second caregiver to assist.

c)The policy further states that education shall be provided to employees on safe lifts/transfers/repositioning including use of mechanical lifts, at orientation. The policy states that this education shall be provided by the person best suited to provide the training, i.e. equipment distributor, Director of Care or designate, educator, physiotherapy staff.
The policy also states that management and registered staff shall monitor the safe resident lifts/transfers/repositioning program to ensure that the respective policies, procedures and protocols are carried out.
An identified Registered Nurse (RN), was not provided safe lifts/transfer education on orientation. The RN was hired over four months ago, and at the time of this inspection has not received training on safe lifts/transfers, although as a registered staff member the RN is responsible for monitoring the program to ensure that the policies and protocols are carried out.
[r.8(1)(b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The home's Abuse and Neglect Resident policy # V3-010 does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.
The home's policy instructs staff to report any knowledge of an incident that constitutes abuse or neglect to the home's Director of Administration or designate. The policy states that it is the responsibility of the Director of Administration to report the incident to the Director under the Act.
The home's policy does not explain that it is the responsibility of any person who has reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to immediately report the suspicion and the information upon which it is based to the Director under the Long-Term Care Homes Act, and that failure by staff to report is an offence under the law. [s. 20(2)(d)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The results of the investigation into an abuse allegation from an identified resident were never reported to the Director under the Long-Term Care Homes Act.
[s.23.(2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The abuse allegation from an identified resident was never reported to the Director under the Long-Term Care Homes Act.
The resident reported that an identified PSW touched him/her in an aggressive manner and spoke to him/her rudely. [s.24(1)2]

The incident was investigated by the home, and the PSW was disciplined with a three day suspension. The employee was also instructed to read and sign the Abuse Residents and Resident Bill of Rights policies. The home could not provide evidence of these signed policies.

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 any allegations of abuse or neglect are reported to the Director under the Long-Term Care Homes Act, to be implemented voluntarily.

Issued on this 4th day of January, 2012

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

Susan Lin (178)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178)
Inspection No. / No de l'inspection :	2011_083178_0024
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Dec 2, 5, 6, 7, 19, 20, 2011
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - LAWRENCE 2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~MARLENE VAN HAM (ACTING)~~ (A) Hyacinth Daley

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

Licensee will develop and implement a process to ensure that staff use safe transfer and positioning techniques when assisting residents, by ensuring that the home's Lifting Devices-Mechanical policy is complied with regarding:
a) the number of staff, and their specific roles, to assist with transfers
b) provision of employee education regarding safe lifts and transfers at orientation, including management and registered staff who will be responsible for monitoring the safe resident lifts/transfers/repositioning program.

Grounds / Motifs :

1. An identified personal support worker (PSW) transferred an identified resident without the assistance of a second person. The PSW also repositioned the resident in bed without any assistance. As a result, the resident sustained a serious injury and required admission to hospital.

2. The home has failed to ensure that it's Lifting Devices-Mechanical policy ("Minimal Lift/Zero Lift Policy"), #V3-850 is complied with.
a)The home's Lifting Device-Mechanical policy states that during a mechanical lift one caregiver operates the lift while the second caregiver guides the resident in the sling.
The inspector was informed by two different identified staff members that they have conducted mechanical lifts while the second person assisting does so by observing from the door of the room, rather than assisting at the resident's side.

b)The home's Lifting Devices-Mechanical ("Minimal Lift/Zero Lift Policy"), # V3-850 states that at least two caregivers shall be present from the beginning to the end of the lift, with one caregiver operating the lift and the other caregiver guiding the resident in the sling.
An identified PSW transferred an identified resident from bed to chair using a mechanical lift alone, with no second caregiver to assist.

c)The policy further states that education shall be provided to employees on safe lifts/transfers/repositioning including use of mechanical lifts, at orientation. The policy states that this education shall be provided by the person best suited to provide the training, i.e. equipment distributor, Director of Care or designate, educator, physiotherapy staff.
The policy also states that management and registered staff shall monitor the safe resident lifts/transfers/repositioning program to ensure that the respective policies, procedures and protocols are carried out.
An identified Registered Nurse (RN), was not provided safe lifts/transfer education on orientation. This RN was hired in July 2011 and as of the time of this inspection has not received training on safe lifts/transfers, although as a registered staff member the RN is responsible for monitoring the program to ensure that the policies and protocols are carried out. (178)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of December, 2011

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

Service Area Office /
Bureau régional de services : Toronto Service Area Office