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 31, 2014	2014_378116_0006	T-674-14	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 - LAWRENCE
2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4

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

SARAN DANIEL-DODD (116)

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): July 8, 21, 22, 23, 2014.

This inspection was performed concurrently with resident quality inspection (RQI) inspection Log #T-58-14 (2014_378116_0005). Findings of non compliance related to s. 6(7) were issued under the RQI report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, personal support workers (PSW) and substitute decision-maker designate for resident #001.

During the course of the inspection, the inspector(s) observed staff to resident interactions, provision of care, lunch meal service, reviewed the health record of resident #001 and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

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 O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (6) A licensee of a long-term care home shall ensure that before a resident of the home leaves for a medical absence or a psychiatric absence, (b) notice of the resident's medical absence or psychiatric absence is given to the resident's substitute decision-maker, if any, and to such other person as the resident or substitute decision-maker designates,

(i) at least 24 hours before the resident leaves the home, or

(ii) if circumstances do not permit 24 hours notice, as soon as possible. O. Reg. 79/10, s. 138 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that before a resident of the home leaves for a medical absence, notice of the resident's medical absence is given to the resident's SDM, if any, and to such other person as the resident or SDM designates, at least 24 hours before the resident leaves the home, or if circumstances do not permit 24 hours' notice, as soon as possible.

Resident #001 was transferred to the hospital on an identified date. The resident's substitute-decision maker (SDM) designate was informed of the hospitalization by the admitting physician requesting further information regarding the resident's advance directives. The home did not notify the SDM designate until the following evening.

Interviews held with the assigned registered staff, Administrator and DOC confirmed that the SDM designate should have been given notice of the medical absence upon transfer. [s. 138. (6) (b)]

Issued on this 9th day of September, 2014

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