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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2015	2014_376594_0017	S-000406-14, S-000396-14	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 - NORTH BAY
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 30, October 01, 02, 03, 2014.

This inspection includes Log#S-000442-14 and was conducted concurrently with Complaint Inspection 2014_376594_0018.

During the course of the inspection, the inspector(s) spoke with Residents, Housekeeper, Environmental staff, Dietary Staff, Unit Schedule Clerk, Resident Relations Coordinator, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Environmental Services Manager and the Administrator.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted daily walk through of the resident care areas and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed, where reasonable grounds to suspect incompetent treatment of a resident that resulted in a risk of harm to the resident has occurred, to immediately report the suspicion and the information upon which it was based to the Director. A report submitted to the Director in 2014 identified that a registered staff member, administered an injection to a resident where the cap of the safety needle had fallen off. Half an hour after the injection to the resident, the registered staff reported discomfort in their finger and noted a puncture mark. The registered staff confirmed to the Director of Care that they did not sustain a needle stick injury after the injection was administered to the resident, thus the resident was administered an injection with a contaminated needle.

Inspector #594 reviewed the home's investigation notes, including an email from the Director of Care to a Consultant. According to the same email the Director of Care had briefly spoken with the registered staff, and had concerns for resident and staff follow up because of the resident receiving a needle stick injury. In a follow up email the Consultant told the Director of Care, the registered staff member was negligent in their practise, putting the resident at risk.

The registered staff was issued a disciplinary letter stating their actions had been confirmed to be negligent and dangerous causing a high risk of injury to a resident. Their actions and behaviours were deemed to have been negligent and reckless and were in violation of Leisureworld's policies including, but not limited to the Resident Bill of Rights, Medication Incident Reporting, Employee Conduct and Resident Abuse.

Given the Director of Care had concerns about improper or incompetent treatment or care of the resident, but a report was not submitted to the Director until two weeks after the incident, the licensee has failed to immediately report this suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 where reasonable grounds to suspect improper or incompetent treatment of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur, the suspicion and the information upon which it is based is immediately reported to the Director, to be implemented voluntarily.

Issued on this 27th day of January, 2015

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

Original report signed by the inspector.