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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2014	2014_283544_0008	S-000482, 510, 515, 431-13	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 - NORTH BAY
401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5

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

FRANCA MCMILLAN (544)

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): February 18, 19, 20, 21, 2014

Ministry of Health and Long-Term Care Logs:
S-000482-13
S-000431-13
S-000510-13
S-000515-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI/MDS Co-ordinator, Registered Staff, Personal Support Workers (PSWs), Residents and Families.

During the course of the inspection, the inspector(s) observed daily the direct delivery of care and services to the residents, staff to resident interactions, the daily activities and behaviours of the residents involved in the critical incidents, reviewed the residents' health care records, care plans and point of care documentation, reviewed the home's Responsive Behaviours Program, Falls Prevention Program and Critical Incident Response Reporting, reviewed staff education, training and staff attendance records in regards to the Falls Prevention Program and Responsive Behaviours Program

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 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):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Resident # 006 had a fall in their room in November 2013 and sustained a laceration. Resident # 006 was sent to the North Bay Regional Health Centre for assessment.
The resident remained in hospital overnight for observation. The laceration was closed with three (3) staples then returned to the long-term care home.
The fall occurred in November, however, the Director was not informed of the incident within one (1) business day after the occurrence of the incident.

Resident # 003 had a fall in December 2013. A post falls assessment was conducted immediately, head injury routine was initiated and the physician was notified.
A head to toe assessment was done by the Registered Nurse. There was no obvious deformity or redness as documented by the Registered Nurse who assessed the resident. Resident # 003 was transferred back to bed by mechanical lift.
During the week, the resident's pain increased and there was an increase in swelling and bruising.
The Resident was sent to North Bay Regional Health Centre for further assessment where it was identified that the resident had sustained a fracture. Resident #003 returned to the long-term care home after having surgery to repair the fracture.
The incident was not reported to the Director no later than one (1) business day after the critical incident.

The licensee did not ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incidents. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital. A "significant change" means a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition and requires an assessment by the interdisciplinary team or a revision to the resident's care plan. [s. 107. (3)]

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Issued on this 25th day of February, 2014

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

Jessica McMillan #544