



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2013	2013_102116_0046	T-374-13	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 - O'CONNOR GATE  
1800 O'Connor Drive, East York, ON, M4A-1W7

**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 Critical Incident System inspection.

This inspection was conducted on the following date(s): October 1,2, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care, Programs Manager, Resident #1, Registered staff and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the health record of Resident #1, employee file, homes internal investigation, education in-service documentation and the following home policies: Resident Bill of Rights and Zero Tolerance of Abuse.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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



<p>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.)</p>	<p>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.</p>
<p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

- s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that Resident #1 was properly cared for in a manner consistent with his or her needs.

- Resident #1 requires two staff assistance to reposition and turn in bed due to decreased mobility as per the plan of care.
- During an interview, an identified personal support worker (PSW) confirmed repositioning Resident #1 without obtaining the assistance of another person on a specified date. As a result, Resident #1 sustained bruising to an identified area of his/her body. Resident #1 confirmed to the inspector that the actions of the PSW were unintentional.
- The home conducted an investigation which resulted in discipline of the PSW. Retraining on applicable home policies were provided to the PSW [s. 3. (1) 4.].



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***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 Resident #1 is properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.***

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Issued on this 7th day of October, 2013

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

A handwritten signature in black ink, appearing to read "S. Daniels", is written in the signature box.