Ministry of Health
and Long-Term Care

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Toronto Service Area Office

55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
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Ministère de la Santé
et des Soins de longue durée

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Toronto

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Ontario

FEB 0 2 2011

Ms. Jane Noble
Administrator
Leisureworld Caregiving Centre – St. George
225 St. George Street
Toronto, ON M5R 2M2

Dear Ms. Noble:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted **November 8, 2010** under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Toronto Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

A. Daniel-Dodd

for Saran Daniel-Dodd
LTC Homes Inspector

Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 8, 2010	2010_116_2594_20Dec122529	Complaint

Licensee/Titulaire

Leisureworld Senior Care LP on Behalf of 2063414

Long-Term Care Home/Foyer de soins de longue durée

Leisureworld Caregiving Centre- St. George

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

Saran Daniel-Dodd, Nursing Inspector

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, and Resident Service Coordinator.

During the course of the inspection, the inspector: reviewed the health record of a resident, interviewed the Administrator, Director of Care, and Resident Service Coordinator.

The following Inspection Protocols were used in part or in whole during this inspection:
Admission and Discharge inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the Nursing Homes Act, R.S.O. 1990, Chapter N7, Section 48(1).
No licensee shall discharge a resident from a nursing home unless permitted or required to do so by this section or section 47.1. O.Reg.181/95, s.3 (1).

Findings: This provision is contravened as evidenced by:

- **Resident was removed from the home and subsequently transferred to hospital.**
- **The licensee discharged the resident to hospital.**

Inspector ID #:	116

WN #2: The Licensee has failed to comply with the Nursing Homes Act, R.S.O. 1990, Chapter N7, Section 48(5).
Before discharging a resident from a nursing home under clause (2) (b) or (c), the licensee of the home shall assist the resident and the person who is lawfully authorized to make a decision on the behalf of the resident concerning the resident's personal care to plan for the discharge, by identifying alternative accommodation, service organizations and other resources in the community.

Findings: This provision is contravened as evidenced by:

- **Resident was discharged from the home. The licensee did not assist the resident in arranging alternative accommodations to meet his/her personal care needs.**
- **The licensee did not inform the resident or SDM of the discharge.**

Inspector ID #:	116

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). December 23, 2010