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*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 4, 2011	2011_147_2911_04Feb112248	Critical Incident – H-00053

Licensee/Titulaire
2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd.
Suite #200
Markham, ON
L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Brampton Meadows
215 Sunny Meadows Blvd
Brampton, ON
L6R 3B5

Name of Inspector

Laleh Newell - #147

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to improper treatment of a resident that resulted in injury.

During the course of the inspection, the inspector spoke with:

Director of Care, Administrator and RAI Coordinator.

During the course of the inspection, the inspector:

Reviewed resident's clinical chart, reviewed licensee's Abuse and Neglect Policy and internal investigation and incident report.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect & Retaliation

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

[3] WN
[3]VPC

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 LTCHA, 2007, S.O. 2007, c.8, s. 19(1)
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. An identified resident sustained an injury while two staff were positioning the resident in bed.
2. As per interview with the Director of Care the staff were aware of the correct method of positioning resident in bed however, did not ensure the bed was lowered prior to positioning the resident in bed.

Inspector ID #:	147

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 all residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s. 36
Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents

Findings:

1. An identified resident sustained an injury while two staff were positioning the resident in bed.
2. The home failed to ensure the staff utilized safe positioning techniques when assisting resident which resulted in injury.

Inspector ID #:	147

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 all staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (10)(b)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

Findings:

1. An identified resident sustained an injury while two staff were positioning the resident in bed.
2. The resident's plan of care did not reflect the resident's care needs had been reassessed related to pain due to injury the resident sustained as a result of the improper positioning by staff.

Inspector ID #:	147

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 all resident's plan of cares are reviewed and revised at any other time when the resident's care needs change, to be implemented voluntarily.

[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). Apr 15/14