Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 13, 16, 17, Jun 1, 7, 9, 10, 15, 2011	2011_070141_0001	Complaint

Licensee/Titulaire de permis

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 CAREGIVING CENTRE - BRAMPTON MEADOWS
215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Social Worker, registered staff, Personal Support Workers (PSWs), Community Care Access Centre (CCAC), and police.

During the course of the inspection, the inspector(s) Reviewed resident's records, home's policy and procedure for Abuse and Neglect, Admission Process, Discharge Resident

The following Inspection Protocols were used in part or in whole during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 19 (1).

Findings/Faits sayants :

1. An identified resident was not protected from emotional abuse by a staff of the home. The Administrator of the home confirmed he was aware of the emotional abuse occurring.
The home's Policy and Procedure "Abuse and Neglect - Resident" (V3-010) states all residents have the right to dignity, respect and freedom from abuse and neglect.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following subsections:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Findings/Faits sayants :

1. An identified resident was discharged by the home without being informed by the Director of Nursing and Personal Care or the resident's physician or a registered nurse in the extended class attending the resident that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following subsections:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits sayants :

1. An identified resident was discharged without the home ensuring that alternatives to discharge had been considered, collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation care and secure environment required by the resident had occurred, ensured the the resident was kept informed of the decision of discharge, and that written notice was provided to the resident setting out a detailed explanation that justified the decision to discharge the resident.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits sayants :

1. An identified resident did not have a 24-hour admission care plan developed to direct care staff within 24 hours of the resident's admission to the home.
The Assistant Director of Nursing confirmed there was no 24 hour care plan developed for this resident and stated that the home practice is to use the electronic MEDe-care plan of care template for the completion of the 24 hour care plan.
The homes policy and procedure for Documentation - 24 Hour Admission Care Plan (V3-502) states:
1. A documented care plan shall be developed for each resident and communicated clearly to direct care staff within twenty-four hours of admission.
6. Ensure that the care plan provides clear direction to staff that provide direct care to the resident and that they have convenient and immediate access to the MEDe-care printed care plan.

Issued on this 17th day of June, 2011

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