



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 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
Direction de l'amélioration de la performance et de la conformité

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row: Nov 21, 22, 23, Dec 6, 2011 | 2011\_063165\_0026 | 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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection. R-002253-11

During the course of the inspection, the inspector(s) spoke with the administrator, the associate director of care, registered staff, personal support workers, and an activation aide.

During the course of the inspection, the inspector(s) reviewed the clinical health record.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. 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

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 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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 subsections:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.**
- 2. An unexpected or sudden death, including a death resulting from an accident or suicide.**
- 3. A resident who is missing for three hours or more.**
- 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.**
- 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.**
- 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee did not inform the director immediately, in as much detail as possible in the circumstances when an unexpected or sudden death occurred. An identified resident died unexpectedly in 2011. The administrator of the home confirmed the home did not consider the death unexpected because the cause of death was determined to be aging and dementia and therefore did not notify the director immediately. However staff interviewed confirmed they were shocked by the sudden death because the resident appeared fine moments preceding the death.

Issued on this 7th day of February, 2012

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


