



**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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2015	2015_337581_0006	H-001615-14	Complaint

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 - BRAMPTON WOODS
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): March 25, 26, 27, 30, 2015.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Registered Dietitian, Food Service Manager (FSM), Food Service Supervisor (FSS), Dietary Aides (DA), families and residents. The inspector during the course of the inspection observed the provision of care and services, observed meal service, reviewed clinical health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<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>The following constitutes written notification of non-compliance under paragraph 1 of section 152 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>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. 6.
Plan of care**



Specifically failed to comply with the following:

- s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
- (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
 - (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**
- s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

Findings/Faits saillants :



1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessments of the resident so that their assessments were integrated, consistent with and complemented each other.

The Dietary Aide on an identified date in March 2015, stated resident #003 received gluten free bread at all their meals as documented on the preference list. Two Dietary Aides stated they have been serving gluten free bread to the resident for the past month and possibly longer and this was confirmed by the Food Service Supervisor (FSS). The resident stated they wanted gluten free bread as they felt bloated with regular bread. During lunch service on an identified date in March 2015, the resident received a gluten free muffin. Review of the written plan of care did not indicate they were to receive gluten free bread at meals. The Dietitian stated they were unaware the resident was receiving gluten free bread at meals and had not received a referral to reassess the resident when their preferences changed. The Dietitian confirmed that their assessments were not consistent and did not complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 was observed on an identified date in March 2015, during lunch service to receive one vegetable serving. Review of the written plan of care indicated they were to receive both vegetable servings with lunch and dinner. The registered staff and dietary aide both confirmed that the resident did not receive both vegetable servings at lunch as specified in the plan. [s. 6. (7)]

Issued on this 30th day of April, 2015

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



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Original report signed by the inspector.