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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **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**
October 25 and 26, 2010	2010_147_2887_25Oct151803	Critcal Incident – H-01834

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 Woods
9257 Goreway Drive
Brampton, ON
L6P 0N5

Name of Inspector

Laleh Newell - #147

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

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

Director of Care, Administrator, staff on the unit and family members.

During the course of the inspection, the inspector:

Reviewed resident's clinical chart, reviewed home's policy and procedure related to Resident to Resident Abuse, reviewed internal incident and investigation reports, observed care, toured the home, and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

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

[2] WN
[1]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 – O.Reg. 79/10, s. 8(1)(b)
8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(b) is complied with.

Findings:

1. An incident of inappropriate touching to a female resident occurred in 2010 by another male resident. This incident was witnessed by the staff on the unit.
2. According to the home's Abuse-Resident – V3-010 policy, the charge nurse is to check resident's condition to assess the safety, emotional and physical well being and to immediately sought medical attention if required.
3. The documentation in the progress notes and the incident reports for both residents does not support that a comprehensive assessment was conducted by the charge nurse as per home's policy and procedure to ensure the safety, emotional and physical well being of the residents was assessed and if any immediate medical attention was required.

Inspector ID #:	147

WN #2 The Licensee has failed to comply with – LTCHA, 2007, S.O. 2007, c. 8, s.19(1)
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 incident of inappropriate touching to a female resident occurred at in 2010 by another male resident. This incident was witnessed by the staff on the unit.
2. According to the home's Risk Indicator Resident Incidents report, the male resident has had 18 incidences of physical and inappropriate behaviours in 2010, which had placed vulnerable residents at risk for abuse, harm or risk of harm.

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 protected from abuse by anyone, 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.**
	Aug 30/11 Revised August 30, 2011 for the purpose of publication
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).