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

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☐ 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
February 4, 2011	2011_107_2570_01Feb144545	Complaint H-00122

Licensee/Titulaire
2063414 Ontario Limited as General Partner of 2063414 Investment LP, 302 Town Centre Blvd., Suite #200, Toronto ON, L3R 0E8
Fax: 905-415-7623

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Brantford
389 West Street, Brantford, ON N3R 3V9
Fax: 519-759-0200

Name of Inspector(s)/Nom de l'inspecteur(s)
Michelle Warrener - #107

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Acting Interim Administrator, Food Service Manager, Resident Relations Coordinator, Director of Administration, Corporate Registered Dietitian, Vice President of President's Council, President of Resident's Council, Personal Support Worker (PSW) staff and residents.

During the course of the inspection, the inspector: Toured the home, observed the noon meal service in the Garden view and Country dining rooms, interviewed residents and staff, reviewed a resident's record.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Dining Observation

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

[2] WN
[2] 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.5
5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

1. Seating in the Country dining room did not provide for a safe environment for both residents and staff. Staff were unable to maneuver between tables when serving food (hot soup) and residents were unable to move out of the dining room without moving other residents. Not all residents were in the dining room during the lunch meal February 4th, 2011, however, traffic flow was obstructed between tables 2 and 4, between tables 3 and 5 and between tables 3 and 4. Also, access to residents in case of emergency is restricted.

Inspector ID #:	107

Additional Required Actions:

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 with ensuring a safe environment for residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.129(1)(a)(ii)
129 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked.

Findings:

1. The medication cart located on the first floor was left unlocked and unsecured on February 4, 2011 at 11:28a.m. When identified by the Inspector, the Administrator of the Home was able to open the cart without staff noticing.

Inspector ID #:	107

Additional Required Actions:

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 with ensuring that medication carts are locked and kept secure at all times, 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.** Y Wanemen
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 24, 2011