



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

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, 11ième étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 20, Dec 2, 2011; 2011\_025168\_0009; 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 - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

LISA VINK (168)

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 the Administrator, the Director of Care, staff from the Hamilton Niagara Haldimand Brant Community Care Access Centre (CCAC) and the resident's Substitute Decision Maker (SDM). Regarding inspection H-002052-11

During the course of the inspection, the inspector(s) reviewed the progress notes for the identified resident and reviewed notes provided by the Resident Relations Coordinator of the home.

The following Inspection Protocols were used during this inspection:

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



Ministry of Health and  
Long-Term Care  
Inspection Report under  
the Long-Term Care  
Homes Act, 2007

Ministère de la Santé et des  
Soins de longue durée  
Rapport d'inspection  
prévues le Loi de 2007 les  
foyers de soins de longue

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 LTCHA, 2007 S.O. 2007, c.8, s. 42. Requirements for admission to home**

The following are required in order for a person to be admitted as a resident of a long-term care home:

1. A placement co-ordinator must have determined that the person is eligible for long-term care home admission under section 43.
2. The placement co-ordinator for the geographic area where the home is located must have authorized the admission of the person to that specific home under section 44. 2007, c. 8, s. 42.

**Findings/Faits saillants :**

1. The admission of the resident to the long-term care home was not authorized by the placement co-ordinator as required.

In 2011 a resident was admitted to the home.

During an interview with the resident's SDM, it was identified that an employee of the home, was the individual who communicated that the resident would be admitted in 2011.

During an interview, with CCAC staff, it was confirmed that the placement co-ordinator did not authorize the admission of the resident to the home until after the resident was admitted to the home.

The CCAC placement co-ordinator authorized the admission of the resident only after notification that the resident had already been admitted to the home.

**WN #2: 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 saillants :**



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  
prévus le Loi de 2007 les  
foyers de soins de longue

1. The licensee did not discharge the resident, as appropriate, ensuring that the SDM was provided the opportunity to participate in discharge planning and taking their wishes into consideration.

An identified resident was discharged from the home in 2011.

During an interview with the SDM in 2011 it was identified that they were not involved in the discharge planning of the resident and that they were told that the resident was being discharged.

Progress notes in the resident's record identify the SDM voiced concerns regarding caring for the resident. Later that same day notes indicate that the physician was contacted and orders were received to discharge the resident.

The SDM of the resident was not given an opportunity to participate the discharge planning before discharge.

Issued on this 23rd day of December, 2011

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

A handwritten signature in black ink, appearing to read "T. Brown".