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**
September 21, 22 & 24, 2010	2010_167_2570_21Sep122800	Complaint related to # H-00628

Licensee/Titulaire

2063414 Ontario Limited as General partner of 2063414 Investment LP
302 Town Centre Blvd.
Suite #200
Toronto, Ontario
L3R0E8

Long-Term Care Home/Foyer de soins de longue durée

Leisureworld Caregiving Centre
389 West Street,
Brantford, Ontario
N3R3V9

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

Marilyn Tone- Nursing- # 167

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: The Administrator, the Director of Care and nursing staff that work on the unit where the identified resident had resided.

During the course of the inspection, the inspector: conducted a review of the identified resident's health file and a review of the home's Falls Risk Prevention policy.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death Inspection Protocol
Personal Support Services Protocol

☒ 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 LTCHA 2007 S.O.2007, c.8 s. 6 (5) & (7).

6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

(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.

Findings:	
1) The Substitute Decision Maker for the identified resident was not notified nor was consent given for all changes to the resident's psychotropic medication profile. A medication was ordered but the resident's SDM was not notified of the addition of this medication. **2)** When the identified resident was admitted to the home, the resident was noted to be very thin and the resident's SDM indicated that the resident had lost a significant amount of weight. The SDM also told staff that the resident had been receiving a supplement prior to admission and that the SDM wished the resident to continue with this treatment. The Registered Dietitian noted on the resident's health file that the resident was at high nutritional risk and the nutritional plan of care indicates that the resident should receive a supplement. This information was not documented on the physician's order form, nor was it relayed to the home's dietary or nursing staff. Consequently, the resident never received the supplement during the time that the resident resided at the home.	
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WN #2: The Licensee has failed to comply with O.Reg. 79/10 s.24(2)1 24(2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.	
Findings: The identified resident was noted to have had frequent falls prior to admission to the home. The resident was also noted to have periods of agitation and wandering/exit seeking. The 24 hour care plan for the resident does not include interventions to mitigate the risks associated with these behaviours.	
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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 that residents' who are newly admitted to the home have a 24 hour care plan in place to address issues of risk, to be implemented voluntarily.	
Inspector ID #:	# 167

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. Marilyn Tone
Title: Date:	Date of Report: (if different from date(s) of inspection). October 12, 2010