Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 22, Oct 3, 19, Nov 24, 29, 2011; Jan 16, 2012	2011_064167_0017	Critical Incident

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Resident Assessment Instrument Coordinator and the Director of Care.
This inspection was related to Log number H-001752-11

During the course of the inspection, the inspector(s) Conducted a review of the health record for the identified resident.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that the written record was kept up to date for the identified resident.

The identified resident passed away at the home. The documentation in the progress notes on the resident's health record during the evening prior to the resident's death indicated that the resident was unresponsive and was unable to take anything by mouth including pills. The resident was noted to have received narcotic medication for comfort. The identified resident's family requested to be notified if the resident's condition changed. It was noted in the same progress note that the staff would continue to monitor.

There was no documentation in the identified resident's health file related to their condition or any monitoring activities that took place during the next shift.

The next progress note was noted to be the following morning and this progress note indicated that the physician was called and information was provided. It was noted that the physician would notify the coroner if necessary. The next note the same day indicated that the physician called to say that they had spoken with the coroner and that the coroner would be in to review the resident's chart.

There was no documentation on the identified resident's health file to indicate the time of the resident's death, whether family were notified of their death and when, when the resident's body was released to the funeral home, when the coroner visited the home to review the chart or the cause of death as determined by the coroner.

Issued on this 21st day of February, 2012

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

Marilyn Jones