



**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 sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

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

**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|------------------------------------------------|-----------------------------------------------|--------------------------------|----------------------------------------------------|
| Jan 22, 2013                                   | 2013_207147_0002                              | H-000605-<br>12                | 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 - BRAMPTON WOODS

9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

LALEH NEWELL (147)

**Inspection Summary/Résumé de l'inspection**



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

This inspection was conducted on the following date(s): January 14, 15 and 16, 2013

H-000605-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC) and RAI Coordinator.

During the course of the inspection, the inspector(s) reviewed resident's clinical record, home's internal investigation and home's policy and procedure related to Abuse and Neglect

The following Inspection Protocols were used during this inspection:  
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES |                                       |
|----------------------------------------------|---------------------------------------|
| Legend                                       | Legendé                               |
| WN – Written Notification                    | WN – Avis écrit                       |
| VPC – Voluntary Plan of Correction           | VPC – Plan de redressement volontaire |
| DR – Director Referral                       | DR – Aiguillage au directeur          |
| CO – Compliance Order                        | CO – Ordre de conformité              |
| WAO – Work and Activity Order                | WAO – Ordres : travaux et activités   |



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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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

An incident of an allegation of abuse was reported to the home in February 2012 by a resident's family member to the registered staff. A Critical Incident was submitted to the Director, however there is no evidence to support that the results of the internal investigation was reported to the Director to date. [s. 23. (2)]



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**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 to ensure that the licensee shall report to the Director the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b). 2007, c.8, s.23(2)., to be implemented voluntarily.*

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
  - 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
  - 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**
  - 4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).**
  - 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**
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**Findings/Faits saillants :**

**1. The home failed to ensure that the incident of allegation of abuse of resident #1 by a family member was reported to the director immediately.**

An incident of an allegation of abuse was reported to the home in February 2012 by a resident's family member to the registered staff. The family member reported to the registered staff regarding injuries to the resident and indicated to the DOC the following day that it was felt that the injuries were caused by a staff member in the home. The home did not report the incident of an allegation of abuse to the Director which was reported to the home by the family member within the time frame as specified. [s. 24. (1)]



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**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 to ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which is based to the Director: Abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**

**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**

**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**

**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when, the resident's care needs change or care set out in the plan is not longer necessary.

Review of resident #1 plan of care indicated the resident was to have a shower with two person total assistance twice a week. Review of the resident's Weekly Skin assessment and the PSW Documentation Records for a several month period indicated the resident had been refusing showers on a regular basis. Interview with the DOC and ADOC indicated that there has been no reassessment related to alternate interventions related to resident's refusal of bathing. [s. 6. (10) (b)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**



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Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

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**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #1 was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. Review of the resident's plan of care indicated the resident was to have a shower with two person total assistance twice a week. However, review of resident #1 Weekly Skin Assessment and the PSW Documentation Records for a several month period indicated the resident did not receive two baths a weeks on a consistent basis and there is no documentation to support that alternative methods of bathing were offered. [s. 33. (1)]

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Issued on this 22nd day of January, 2013

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

A handwritten signature in black ink, appearing to be "J. M. M.", written over a horizontal line.