



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

**Rapport d'inspection
prevue 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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton, ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ième} étage
Hamilton, ON L8P 4Y7

**Ministère de la Santé et des Soins de
longue durée**

Telephone: 905-546-8294
Facsimile: 905-546-8255

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

☐ 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
January 14, 2011	2011-120-2570-14Jan112252	H-03116 - Critical Incident H-03120 - Critical Incident H-00177 – Follow-up to Dec. 9/10
Licensee/Titulaire		
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 Brantford, 389 West Street, Brantford, ON N3R 3V9		
Name of LTC Homes Inspector(s)/Nom de l'inspecteur(s) de les foyers de soins de longue duree		
Bernadette Susnik, Environmental Health #120		

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a follow-up inspection to December 9, 2010 and to review 2 Critical Incidents related to resident elopements.

During the course of the inspection, the above noted inspector spoke with the acting administrator and the maintenance supervisor. During the course of the inspection, the inspector reviewed all perimeter door access control systems and the resident-staff communication and response system.

The following Inspection Protocol was used during this inspection:

- *Safe and Secure Home*

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

3 WN
2 VPC
2 CO: #001, #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoie
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'exigences prévue le paragraph 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 O. Reg. 79/10, s. 17(1)(f) & (g).* Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

- (f) clearly indicates when activated where the signal is coming from, and
- (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Findings:

- The nurse call system was designed and installed in the new section of the home, encompassing the Forest View Dining area, Pleasant Care wing and the Forest View wing for staff to wear pagers to determine the source of the signal. Pagers were not available during the review and staff were not wearing them. A secondary source of sound however is available in the two corridors, however the sound is not audible throughout the home area. 1 speaker has been installed in the Forest View corridor near room #106 and another two have been installed near rooms #114 and #127 in the Pleasant Care corridor. These sources of sound are not calibrated to be equally audible throughout the home area, which cannot be heard into the Forest View dining room or lounges/activity rooms.
- The nurse call system in the old section of the home, encompassing the Gardenvue dining room, Courtyard dining room and the 4 corridors known as Autumn Garden (A wing), Clearview, Scenic Way and Homestead Hall (B wing) uses sound to alert staff when a nurse call has been activated. The sound emitter and enunciator panel is located only at the nurse's station at the front of the home, near the main set of entrance doors. As one moves away from this station, the sound is not calibrated such that it can be audible throughout the home area, down each corridor.

Additional Required Actions:

VPC - pursuant to the *LTC 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 s.17(1)(f) & (g) with respect to ensuring that the home is equipped with a resident-staff communication and response system that, (f) clearly indicates when activated where the signal is coming from, and (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. The plan is to be implemented voluntarily.

WN #2: *The licensee has failed to comply with O. Reg. 79/10, s. 9.1.i & iii, A. & B.* Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home must be,
 - i. kept closed and locked,
 - iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
 - A. is connected to the resident-staff communication and response system, or
 - B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Findings:

- Doors located in the Garden View and Forest View dining areas, which lead to outdoor courtyards, were found to be unlocked during the inspection. Both of these doors are not designated fire exits and have key locks on the doors. Keys to the Garden View courtyard door could not be located at the time of inspection.
- The glass door near the nurse's station, in the old section of the building, did not have a locking mechanism on it and was therefore unlocked. This door is a designated fire exit door with alarm only.
- The doors located in the new section of the building, at the end of the Forest View corridor, at the end of the Pleasant Care corridor (#904) and a door labeled as #901 in the hall towards the old section of the building were tested and did not alarm to the resident-staff communication and response system. Doors did not alarm, after being held open between 2 and 5 minutes. Nursing staff who were at the nurse's desk were approached and asked if they saw any of these doors light up on the enunciator panel and they said no. They said that door number #907 typically rings which is likely the Forest View dining room door to the courtyard.

Additional Required Actions:

CO - #001 - Refer to the attached "Orders of an Inspector" form. The Order was faxed on Feb. 7, 2011.

WN #3: *The licensee has failed to comply with O. Reg. 79/10, s.104(1)4.ii.* Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

4. Analysis and follow up action, including,
 - ii. the long- term actions planned to correct the situation and prevent recurrence.

Findings:

The critical incident report #2570-000058-10 submitted on December 29, 2010 for a resident who eloped from the home did not provide long-term actions planned to correct the situation of continual elopement and to prevent recurrence. The statement made on the report is as follows:

"continue to evaluate mobility status, to involve physio to strengthen and for gait training as applicable and educate staff on alarms and importance of immediate action".

The statement does not effectively address the situation nor does it offer any long-term plans to correct the situation to prevent recurrence.

A voluntary plan of correction was requested but not developed for a Written Notification issued by LTC Homes Inspector Richard Hayden on December 9, 2010 regarding unlocked doors. The only documentation acquired during the inspection shows that the home has received quotes from several companies to install magnetic locking systems on various doors. No action plans were available to determine how residents would be kept safe and from wandering out of the building until the locks could be installed.



Additional Required Actions:

CO - #002 Refer to the attached "Orders of an Inspector" form. The Order was faxed on February 7, 2011.

Signature of Licensee of Designated Representative
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.

B. Susnik

Title:

Date:

Date of Report : (if different from date(s) of inspection).

Feb. 11/11

**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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public
Name of Inspector:	Bernadette Susnik	Inspector ID # 120
Log #:	H-03116	
Inspection Report #:	2011-120-2570-14Jan112252	
Type of Inspection:	Critical Incident #2570-000058-10	
Date of Inspection:	January 14, 2011	
Licensee:	2063414 Ontario Limited as General Partner of 2063414 Investment LP	
LTC Home:	Leisureworld Brantford, 389 West Street, Brantford, ON N3R 3V9	
Name of Administrator:	Andrea McLister (Acting)	

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order by the date set out below:

Order #:	001	Order Type:	Compliance Order, Section 153 (1)(a)
Pursuant to:			
O. Reg. 79/10, s. 9.1.1. Every licensee of a long-term care home shall ensure that the following rules are complied with: 1. All doors leading to stairways and the outside of the home must be, i. kept closed and locked,			
Order:			
The Licensee shall ensure that;			
- all doors leading to outdoor areas, such as the doors located in the Garden View and Forest View dining areas and the glass door, near the nurse's station in the old section of the building, are to be kept locked. For those doors that are designated fire exits, the locking mechanism must release when a fire alarm is engaged. - all staff receive training on how the locking mechanisms function and their purpose. - a policy is developed that describes staff roles and responsibilities should the locking mechanisms fail.			

- The policy shall describe who is responsible and what actions are required for the care and maintenance of the new locking mechanisms.
- all staff are made aware of the policy.

Grounds:

- Doors located in the Garden View and Forest View dining areas, which lead to outdoor courtyards, were found to be unlocked during the inspection. Both of these doors are not designated fire exits and have key locks on the doors. Keys to the Garden View courtyard door could not be located at the time of inspection.
- The glass door near the nurse's station, in the old section of the building, did not have a locking mechanism on it and was therefore unlocked. This door is a designated fire exit door with alarm only.

This order must be complied with by: February 28, 2011

Order #: 002	Order Type: Compliance Order, Section 153 (1)(b)
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Pursuant to:

O. Reg. 79/10, s.104(1)4.ii. Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

4. Analysis and follow up action, including,
 - ii. the long- term actions planned to correct the situation and prevent recurrence.

Order:

The licensee shall;

1. Prepare, submit and implement a plan that describes what short- term and long -term actions have been taken or will be taken to ensure that residents who are not authorized to leave the building, are kept safe from wandering out of the building.

Grounds:

The critical incident report #2570-000058-10 submitted on December 29, 2010 for a resident who eloped from the home did not provide long-term actions planned to correct the situation of continual elopement and to prevent recurrence. The statement made on the report is as follows:

"continue to evaluate mobility status, to involve physio to strengthen and for gait training as applicable and educate staff on alarms and importance of immediate action".

The statement above does not effectively address the situation nor does it offer any long-term plans to correct the situation to prevent recurrence.

A voluntary plan of correction was requested but not developed for a Written Notification issued by LTC

**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

Homes Inspector Richard Hayden on December 9, 2010 regarding unlocked doors. The only documentation acquired during the inspection shows that the home has received quotes from several companies to install magnetic locking systems on various doors. No action plans were available to determine how residents would be kept safe and from wandering out of the building until the locks could be installed.

This order must be complied with by: February 9, 2011

REVIEW/APEAL INFORMATION**TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

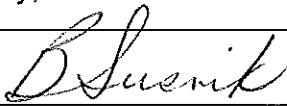
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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 7th day of February, 2011.	
Signature of Inspector:	
Name of Inspector:	Bernadette Susnik
Service Area Office:	Hamilton