



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
prévus 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
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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
Dec 14, 16, 2011; Jan 18, 2012	2011_060127_0056	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

RICHARD HAYDEN (127)

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 administrator, director of care and a resident regarding H-002389-11.

During the course of the inspection, the inspector(s) reviewed management's documentation of their investigation; reviewed a resident's chart and electronic record; and reviewed an employee's personnel file.

The following Inspection Protocols were used during this inspection:

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.)	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to immediately investigate an incident of alleged resident abuse. The Critical Incident System Report indicated an incident of alleged resident abuse occurred but was not reported to the Director named in the LTCHA, 2007, until seven days later. In a related complaint report, an identified resident stated the incident happened early in the morning and management's investigation/interview notes with the accused staff member indicated it happened while providing morning care to the resident.

The director of care (DOC) could not produce any investigation notes that were dated less than ten days following the incident when he/she and the administrator took notes during an interview with the accused staff member. The DOC stated he/she met with the identified resident to discuss the incident and to let him/her know that management was investigating his/her complaint but did not have any documentation to support that statement.

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 with immediately investigating, responding to and acting upon every alleged, suspected or witnessed incident of abuse of a resident by anyone, to be implemented voluntarily.

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



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Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
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).

Findings/Faits saillants :

1. The licensee failed to immediately report a suspicion of resident abuse, and the information upon which it was based, to the Director named in the LTCHA, 2007. The Critical Incident System Report indicated an incident of alleged resident abuse occurred but was not reported to the Director named in the LTCHA, 2007, until seven days later. In a related complaint report, an identified resident stated the incident happened early in the morning and management's investigation/interview notes with the accused staff member indicated it happened while providing morning care to the resident.

Issued on this 6th day of February, 2012

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