



**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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Public Copy/Copie du public

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	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
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 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



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

Marilyn Lone