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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 18, 2014	2014_266527_0001	H-000506-13 AND H-000293-13	Complaint

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - MISSISSAUGA
2250 HURONTARIO STREET, MISSISSAUGA, ON, L5B-1M8

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

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 13 and 14, 2014.

The Inspector conducted two inspections: H-000293-13 and H-000506-13.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Personal Support Workers (PSW), Registered Nursing Staff, Directors of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed the residents clinical records, policies and procedures, the critical incident investigation notes, root cause analysis of medication incident, staff meeting minutes, training records , medication incident report, and corporate correspondence.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 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).

Findings/Faits saillants :

1. The licensee did not 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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

Resident #001 returned from the hospital on June 25, 2013 and the physician had ordered a new medication (Warfarin). In addition, the physician ordered an International Normalized Ratio (INR) blood test to ensure the medications where maintained in a therapeutic range.

The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) for June 27, 2013 identified changes in resident status related to a new high risk medication and the necessary laboratory testing. These changes were not transcribed into the written plan of care dated July 1, 2013. The Director of Care and registered staff confirmed this information was not updated in the revised plan of care. The resident received the wrong dosage of medication for twenty-three days before the medication error was identified, the INR testing was not performed weekly. The resident developed a right chest wall and intra-abdominal bleed, which required admission to the hospital. [s. 6. (10) (b)]

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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the new drug administered to resident was in accordance with the directions for use specified by the prescriber.

The physician ordered Warfarin 0.5 mg orally once daily on June 25, 2013. The Warfarin order was sent to the pharmacy service provider and when the Medication Administration Record (MAR) returned to the home it was documented as Warfarin 5 mg. The registered staff did not complete checks on the new MAR to ensure the Warfarin was documented as specified by the prescriber and prior to administration of the new medication, therefore the resident received the wrong dosage from June 25, 2013 to July 18, 2013 (23 days). The resident was transferred to the hospital on July 19, 2013. The resident was admitted to the hospital with a diagnosis of a supratherapeutic INR, which was greater than 10, and a major bleed.

Registered staff and the Director of Care confirmed that registered staff are expected to do three checks of the physicians orders and new MAR when a new medication is ordered and when a resident returns from the hospital. Based on the review of the MAR sheets, and confirmed with the Director of Care, there were no MAR checks completed. [s. 131. (2)]

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 new drugs administered to residents are in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. On June 25, 2013 the physician ordered an INR check on Thursday this week and next week, then check on Monday weekly.

There were no laboratory requisitions made out and no INR blood tests done after Thursday, June 27, 2013, until the resident was admitted to the hospital on July 19, 2013. The Director of Care confirmed the INR was documented to be done on June 27, 2013, however staff did not complete the process to ensure the INR was then done weekly. Registered staff confirmed they did not complete the procedures as per the Medication Management - Anticoagulant Medications and INR policy, Number: V3-140 (a) dated April 2013. The resident was admitted to the hospital with a diagnosis of supratherapeutic INR of greater than 10 and a major bleed. [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

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Issued on this 18th day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Kathleen Millar (ID 527)