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
Oct 15, 2013	2013_162109_0037	T-364-13	Critical Incident System

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 - BARRIE
130 OWEN STREET, BARRIE, ON, L4M-3H7

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 8 & 10, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Registered staff, Personal Support Workers, Physiotherapist.

During the course of the inspection, the inspector(s) Conducted a walk through of the care unit and tub room, reviewed the health record for resident # 1, reviewed the pain management policy.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Pain

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident was reassessed and the plan of care was being revised because the care set out in the plan was not effective, that different approaches have been considered in the revision of the plan of care in relation to pain management.

Resident # 1 fell during an improper transfer on an identified date and sustained a fracture. The resident started to experience pain 24 hours after the fall and an initial x -ray was inconclusive and indicated that a follow up x-ray should be done to assess for an occult fracture if the acute symptoms persist. The resident continued to complain daily of severe pain in her/his left groin and leg during care. The progress notes for the identified dates indicate that the resident complained about pain and screamed out in pain during care. The pain assessment completed on an identified date indicated that the resident described her/his pain to be excruciating up and down her/his left leg and groin.

The resident did not receive another x-ray until several days later on an identified date when the resident was transferred to the hospital for an assessment. The new x-ray revealed a subcapital femoral fracture with superior and lateral displacement of the distal femoral component.

The resident was previously prescribed a routine analgesic three times per day for pain. There was another PRN order for an analgesic to be administered when needed. The resident continued to complain of pain every day despite receiving the routine analgesics. There was no PRN analgesics administered from when she/he first began to experience pain until one identified date when she/he was administered the medication during the night for her/his pain. There was no change in the residents pain control measures until after the diagnosis of a fracture.

There was no indication that any different approaches for the pain management interventions were considered for this resident. [s. 6. (11) (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 when a resident is reassessed and the plan of care is being revised because the care set out in the plan was not effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff use safe transferring techniques when assisting residents.

Resident # 1 was assessed as requiring 2 staff for all transfers and toileting. The plan of care states that the resident requires 2 staff for all transfers related to her/his physical decline. Staff interviews revealed that the resident was always transferred by 2 staff members because she/he was not steady and was unpredictable.

On an identified date a staff member took resident # 1 to the tub room and stood the resident up and assisted her/him with toileting activities without assistance from a second staff member. The resident fell while the staff member reached for the wheelchair.

The fall resulted in a fracture and the resident died several days later. The cause of death was due to complications of the fracture. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 15th day of October, 2013

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