Ontario

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 prévue 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
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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
Sep 19, 26, 28, 29, Oct 3, 11, Nov 28, 2011	2011_070141_0028	Complaint

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON MEADOWS
215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

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

During the course of the inspection, the inspector(s) reviewed the resident's records, the home's policy and procedure for Skin Care Program, Turning Schedule Tool, and Catheter - Catheterization.

H-001590-11

Inspection 2011-070141-0029 for H-001433-11 and 2011-070141-0030 for H-001233-11 were conducted simultaneously with inspection 2011-070141-0028 for H-001590-11.
This report includes finding for the written notification finding #3, related to the O.Reg 79/10 s.8.(1) for inspection 2011-070141-00029 for H-001433-11.
This report includes findings for the written notification finding #4, related to LTCHA s.6.(10)(b) and written notification finding #4, related to O.Reg 79/10 s.8(1) for inspection 2011-070141-0030 for H-001233-11.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Pain

Personal Support Services

Skin and Wound Care

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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. An identified resident was not reassessed and their plan of care reviewed at a time of when care needs were identified as changed. The resident had a history of infections. The progress notes on the evening shift of an identified date in 2011 stated the resident was commenced on a course of antibiotics for a suspected infection. The progress notes of the following day shift stated that the night shift nurse reported a change in the resident's physical status. There was no documentation by the night shift nurse of the resident's change in status, or assessment completed by the nurse including vital signs and actions taken. The day shift nurse stated that they received the resident in bed and left them to sleep because they looked tired. An assessment of the resident did not occur until immediately after the commencement of the shift. The assessment identified a further change in resident physical status. The resident was subsequently transferred to hospital. s.6(10)(b)
2. The plan of care for does not set out clear directions to staff who provide direct care to an identified resident. The resident had a skin breakdown. The physician's orders did not include treatment orders for the wound. The written plan of care did not provide staff direction in the treatment of the wound pertaining to type and frequency of treatment. s.6.(1)(c)
3. The plan of care for does not set out clear directions to staff who provide direct care to an identified resident. The resident had a skin breakdown that deteriorated. Identified interventions in the resident's progress notes were not included in the resident's written plan of care to provide clear direction to direct care staff. s.6.(1)(c)
4.An identified resident was not reassessed at the time of change in their care needs. The resident's progress notes in 2011 stated the resident was having difficulty weight bearing. The registered staff updated the plan of care for the resident related to transfer needs, and completed a referral to physiotherapy. There is no evidence that an physical assessment of the resident was completed by the registered staff prior to the updating of the plan of care. The resident was later transferred to hospital for assessment of injury. 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 when the resident's care needs change, that the plan of care provides clear directions to staff, and that care is provided to residents as specified in their plan of care,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that interventions related to continence care and bowel management were documented for an identified resident. The plan of care for the resident stated that an intervenition was to completed on each shift and documented. The resident's records were inconsistent for documentation of the intervention. s.30(2)
2. The licensee did not ensure that the intervention related to skin care was documented for an identified resident. The resident was to have an intervention completed at regular set intervals daily. There is inconsistent documentation in the resident's PSW Documentation Record and progress notes to indicate that the intervention occurred. s.30(2)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1.An identified resident did not have reassessment of their skin care needs at least weekly by a member of the registered nursing staff. The resident was identified with an unstageable wound in 2011. Weekly skin assessments were not completed consistently in 2011 as required. s.50.(2)(iv)
2. An identified resident did not receive a skin assessment at the time of identified altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In 2011 the resident had new skin breakdown. There is no documented completed assessment using an clinically appropriate assessment instrument designed for skin and wound assessment. Staff confirmed that assessments of skin breakdown are completed in progress notes only. The home's policy and procedure "Skin Care Program" (V3-1400) states a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. s.50(2)(b)(i)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the policy for "Skin Care Program" was complied with for an identified resident. The resident did not have a registered dietitian assess their needs related to altered skin integrity. The home's policy "Skin Care Program" (V3-1400) states that a referral to the Registered Dietitian should be completed for any resident with altered skin integrity. The resident was identified with new skin breakdown in 2011 and there is no documentation to indicate a referral had been sent to dietary concerning the resident's wound or that an assessment had been completed. The nutritional plan of care does identify the existing wound and does not include interventions by dietary to treat the wound. s.8(1)(b)
2. The licensee of the home did not ensure that the Skin Care Program was complied with for an identified resident. The resident was identified with skin breakdown in 2011. Weekly skin assessments were completed in the residents progress notes. The assessments did not consistently describe the current size of the wound. The home's policy "Skin Care Program" (V3-1400) states a wound assessment is to be completed as per the Skin Ulcer Treatment and Assessment Record (template) including measurements (length width and depth) on a weekly basis. The policy states that each dressing change will be documented on the Skin Ulcer Treatment and Assessment Record. The resident's progress notes did not have documentation of each wound dressing being completed and the current description of the size of the wound. s.8.(1)(b)
3. The licensee did not ensure that the policy for "Abuse and Neglect Resident" (V3-010)was complied with for an identified resident. The home's policy and procedure defines abuse of the resident as the action or inaction, misuse of power/or betrayal of trust, respect or intimacy by any person against the resident. A staff member was identified as selling items to an identified resident. The home's investigation verified that financial abuse occurred against an identified resident.
s.8(1)(b)
4. The licensee did not ensure that the pain program was implemented in accordance with all applicable requirements under the Act for an identified resident. The home's policy and procedure "Pain Assessment Tool" (V3-170.1) states that an assessment tool will be used upon admission to assess resident's pain. The assessment tool will be completed upon admission only. The resident was ordered an increase in pain medication at regular intervals when there was a change in status and further pain medication as required. The resident received pain medication for breakthrough pain but the resident's pain was not assessed using a clinically appropriate assessment instrument. Staff confirmed that they do not use a clinically appropriate tool for pain assessment, except at admission. s.8(1)(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 that that policies and procedures are implemented in accordance to all applicable requirements under the Act and are complied with,, to be implemented voluntarily.

Issued on this 1st day of December, 2011

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