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 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
Apr 29, 2014	2014_207147_0004	~~H-000532-13~~ H-000653-13	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 - BRAMPTON WOODS
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

LALEH NEWELL (147)

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): February 6 and 7, 2014

H-000653-13
H-000136-14

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Nurse Practitioner, Registered nurse and resident.

During the course of the inspection, the inspector(s) reviewed residents clinical records, home's internal investigation notes, staff personnel file and home's policy and procedure related to Medication Administration.

The following Inspection Protocols were used during this inspection:
Medication

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure 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 is complied with.

According to the home's policy and procedure - "Prescribing Resident Orders" - V3-1230 last revised on April 2013, prescriptions orders for the residents given by hospitals are to be verified by the resident's attending physician in the nursing home and the registered staff are responsible for first and second checks of all prescribing orders for medication to ensure accuracy in the information and transcription of the medications.

Resident #101 was admitted to the home from the hospital on an identified date in 2013. The nurse transcribed the medication lists from the hospital and contacted the physician on call, who did not review the medications and ordered to continued the medications from the hospital. As a result the resident received several medications in error and duplication of some medications within two days that resulted in the resident being admitted to hospital for further assessment. [s. 8. (1)]

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 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 is complied with, 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 failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescribe.

A. Resident #101 was admitted to the home from the hospital on an identified date in 2013. The nurse transcribed the medication lists from the hospital and contacted the physician on call, who did not review the medications and ordered to continued the medications from the hospital. As a result the resident was administrated several medications that were not in accordance with the direction for the use specified by the prescriber.

B. Review of the home's internal investigation, resident physician orders and interview with the Nurse Manager confirmed the following medications were not administered to five different residents in accordance with the direction for use specified by the prescirber by the Registered Practical Nurse (RPN) during two evening shifts.

i) According to resident #102's physician orders, the resident is to be administered a specified medication at bedtime. The RPN failed to administer this medication to the resident as per physician's orders and documented that the resident had refused, however further investigation by the home revealed that the resident does not have any history of refusing medications.
ii) According to resident #103's physician orders, the resident is to be administered a specified medication orally twice a day. The RPN failed to administer this medication to the resident as per physician's orders and documenting that the medication was not available. However, other registered staff on the unit found the full medication pouch the following day.
iii) According to resident #104's physician orders, the resident is to be administered a specified medication once a day at bedtime. The RPN failed to administer this medication to the resident as per physician's orders on two consecutive days, documenting that the medication was given to the resident. However, other registered staff on the unit found the full medication pouches the following day.
iv) According to resident #105's physician orders, the resident is to be administered three different medications orally twice a day. The RPN failed to administer these medications to the resident as per physician's orders and documenting that the resident was not available, even though the resident was physically in the building during the shift.
v) According to resident #106's physician orders, the resident is to be administered a specific medication orally at bedtime. Review of the home's internal investigations

and interview with the resident indicated that the resident requested the medication at bedtime from the RPN, however the RPN refused the medication to the resident and documented on the MAR to have administering the medication. [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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 29th day of April, 2014

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