Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére 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
Jul 28, Aug 26, 2011	2011_066107_0006	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 - BRAMPTON WOODS
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

MICHELLE WARRENER (107)

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 Administrator, Director of Care, Food Services Manager, Food Services Supervisor, and Nursing staff, in relation to critical incident inspection H-001527-11.

During the course of the inspection, the inspector(s) Reviewed an identified resident's clinical health record.

The following Inspection Protocols were used in part or in whole during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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.) 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 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 sayants :

1. The Home's policy and procedure related to Registered Dietitian referral was not followed in relation to swallowing difficulties experienced by an identified resident. [O.Reg. 79/10, s.8(1)(b)]
The Home's policy identifies swallowing difficulties are to be referred to the Registered Dietitian for assessment, however, this process was not followed and the resident was not assessed by the Registered Dietitian. Management staff interviewed, confirmed a referral to the Registered Dietitian would have been expected for the assessment of swallowing difficulties and the decline in hemoglobin noted in 2011.

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 with ensuring that 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. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits sayants :

1. [O.Reg. 79/10, s.26(4), s. 26(3)13]
The Registered Dietitian who is a member of the staff of the home did not complete a nutritional assessment in relation to reduced swallowing ability noted in 2011 for an identified resident.
A referral to the Registered Dietitian did not occur when the resident began having difficulties swallowing. The Home's "Dietitian Referral Form" identifies swallowing problems as a reason for referral to the Registered Dietitian. The Registered Dietitian confirmed that she did not receive a referral for this resident and that a referral would be expected.

The plan of care was not revised to include risk of swallowing difficulties and not all staff were aware that the resident had swallowing difficulties. One staff member interviewed was unaware that the resident had had swallowing difficulties prior to a choking incident based on reviewing the resident's current plan of care.

The resident's plan of care states to refer back to the Registered Dietitian for a decline in hemoglobin (lower than a specified level). The resident's hemoglobin level decreased below this threshold in 2011, without a referral to the Registered Dietitian for assessment. The Registered Dietitian and Food Services Supervisor confirm a referral was not sent for re-assessment of the resident in relation to swallowing difficulties or a decline in hemoglobin.

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 with ensuring the plan of care is based on, at a minimum, interdisciplinary assessment of nutritional status, including height, weight, and any risks relating to nutrition care, and to ensure that the Registered Dietitian completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and assesses the matters referred to in paragraphs 13 and 14 of subsection (3)., to be implemented voluntarily.

Issued on this 12th day of September, 2011

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