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
Jan 23, 30, 2013	2013_215308_0001	H-000323-12, H-000729-12	Complaint

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

MELODY GRAY (308)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 14, 15, and 16, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Associate Director of Care, the Recreation Manager, Registered staff members, Personal Support Workers and the resident.

During the course of the inspection, the inspector(s) Reviewed the medical records, the home's medication incident reports, and the home's policies and procedures. The linen on beds in three randomly selected residents' rooms and the two west linen closet were inspected. The home was toured and resident care observed.

The following Inspection Protocols were used during this inspection:
Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 drugs administered to a resident in the home had been prescribed for the resident

In April 2012, resident #111 was administered nine medications which had been prescribed for another resident. These medications could potentially have a negative impact on the resident's health condition. This was confirmed through record review and interviews with the home's Director of Care and Associate Director of Care.

In April 2012, resident #3 received a medication which was not prescribed for resident # 3 but prescribed for another resident. This was confirmed through medical record review and interview with the home's Director of Care. [s. 131. (1)]

2. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

In February 2012, resident #111 was ordered treatments for seven days. Documentation in the resident's Medication Administration Record does not include initials of staff documenting that the treatments were administered on four of the seven days. When the resident visited the specialist, the treatment had to be re-ordered and repeated. This was confirmed through interview with the home's Director of Care.

In May 2012, resident #2 received the wrong dose of a medication. The medication dosage was decreased instead of increased as per the doctors order on the home's Medical Directive. This was confirmed through record review and interview with the home's Director of Care. [s. 131. (2)]

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Issued on this 30th day of January, 2013

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