Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Inspection Report under the LTC Homes Act, 2007 ☒ Public Copy ☐ Licensee Copy	**Rapport d'inspection prevue de le Loi de 2007 les foyers de soins de longue durée** ☐ Copie du Titulaire ☒ Copie de la Publique	
Date(s) of inspection/Date de l'inspection July 21, 22, 2010	**Inspection No/ d'inspection** 2010-141-2570-20Jul132658	**Type of Inspection/Genre d'insptection** Complaint H-00098
Licensee/Titulaire 2063414 Ontario Limited as General Partner of 2063414 Investment LP, 302 Towne Centre Blvd., Suite 200, Markham, On, L3R 0E8		
Long-Term Care Home/Foyer de soins de longue durée Leisureworld Caregiving Centre - Brantford, 389 West Street, Brantford, On, N3R 3V9		
Name(s) of the Inspector(s) conducting the Inspection/Nom de l'inspecteurs qui fait de l'inspection Sharlee McNally LTC Homes Inspector – Nursing # 141 and Lesa Wulff LTC Homes Inspector Nursing # 173		

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection received at the Hamilton Service Area Office on July 8, 2010 (IL-13713-HA, Log #00098) concerning resident care and staffing levels.

The inspection was conducted by 2 Inspectors identified above.

The inspection occurred on July 21 and 22, 2010 with both inspectors being present on both days.

During the course of the inspection, the inspectors spoke with:
members of the management team including the Administrator and Director of Care, RAI-MDS Coordinator and RAI-MDS Back up Coordinator, Leisureworld corporate consultants, residents, staff on all resident home areas.

The following Inspection Protocols were used during the inspection:
- **Skin and Wound Care Inspection Protocol**
- **Medication Inspection Protocol**

Eight findings of non-compliance were found during this inspection. The following action was taken:
- **10 WN**
- **7 VPC**

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O 2007, c. 8, s.6(1)(c): Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The plan of care for an identified resident did not include the intervention of administration of medication for pain prior to dressing changes of a wound, as ordered by the physician.

2. The plan of care for an identified resident does not include a current accurate description of an identified wound.

VPC – pursuant to LTCHA, 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 insuring there is a writing plan of care for each resident that sets out clear directions to staff who provide direct care to the resident, to be implemented voluntarily.

Inspector ID# - 141

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O 2007, c. 8, s6(10)(b): 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, the resident's care needs change or care set out in the plan is no longer necessary;

Findings:

1. Newly identified wounds in which treatment had been initiated for an identified resident did not have evidence of an assessment completed to identify the specifics of the wound and care required. There was no documentation of an assessment completed to indicate type, location and cause of wound and specific treatment that had been initiated.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

2. Progress notes an identified resident identified history of dressings to the wounds being changed more frequently than directed due to heavy exudates initiating from the wound. The dressing was observed to be full of exudates and there was overflow causing staining on linens under the wound during the inspection dates. The progress notes did not identify re-assessment of the dressing had been completed and the plan of care did not include interventions for monitoring need for dressing changes related to excessive wound exudates.

VPC – pursuant to LTCHA, 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 their plan of care reviewed and revised when the residents care need change, to be implemented voluntarily.

Inspector ID# - 141

WN #3: The Licensee has failed to comply with LTCHA 2007, S.O 2007, c. 8, s6(7)
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7)

Findings:

1. An identified resident's wound dressing, observed during the inspection dates did not reflect the current physician treatment order. It was noted that the required treatment supplies were available in the home. Further discussion with the staff member, who completed the dressing change, indicated that the staff was aware that the incorrect treatment was applied.

VPC – pursuant to LTCHA, 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 care set out in the plan of care is provided to the resident , to be implemented voluntarily.

Inspector ID# - 141

WN #4: The Licensee has failed to comply with O. Reg 79/10, 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.

Findings:

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

1. Review of an identified resident's records indicated a medication error. As a result the physician was notified but there was a delay in treatment due to the wrong physician being contacted initially. The physician ordered that the resident be transferred to hospital related to identified changes in residents physical and cognitive status
2. Review of identified resident's records indicated a medication error in which the resident received another resident's prescribed medication. As a result there was change in the resident physical status

Inspector ID# - 141 and #173

WN #5: The Licensee has failed to comply with O. Reg. 79/10, s135(2)(a)
Every licensee of a long-term care home shall ensure that in addition to clause (1)(a, shall ensure that all medication incidents and adverse drug reaction are documented, reviewed and analyzed.

Findings:

1. The home's Medication Incident Report for a medication error for an identified resident does indicate reason for error but the report does not include details of specific actions taken related to resident as result of error . The report does not indicate that the Director of Care has reviewed it, as indicated by lack of signature.

Inspector ID# - 141

WN#6: ***THE LICENSEE HAS FAILED TO COMPLY WITH THE*** **Long-Term Care Homes Program Manual Standards and Criteria**
R8.1: All medication errors and adverse drug reactions shall be reported promptly to the director of nursing, prescriber, and pharmacist according to established policy and procedure and specific follow-up action shall be taken.

1. Home's Medication Incident Report for medication error for an identified resident was completed by a registered staff and signed as reviewed by the Director of Care. The report does not provide details related to circumstances leading up to the error in medication administration. There was no investigation found that had been completed by the Director of Care related to analyzing the error to prevent reoccurrence.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

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WN #7: The Licensee has failed to comply with O. Reg. 79/10, s50(2)(b)(ii)
Every licensee of a long-term care home shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Findings:
1. An identified resident's wound was observed during the inspection period with the dressing not intact leaving the wound partially exposed and in direct contact with a non sterile soaker pad. The dressing was noted to be over full with sero-sanguinous exudates and there was also exudates evident on the soaker pad.
The identified resident's most current pain assessment indicates that the resident is on routine pain medication and also has pain medication as necessary with dressing change. The resident's records indicate the pain medication is effective for discomfort at the time of wound dressing changes. Medication Administration Records (MAR) indicate that the resident has only received the medication twice in the current month for approximately 7 dressing changes.

VPC – pursuant to LTCHA, 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily

Inspector ID# - 141

WN #8: The Licensee has failed to comply with O. Reg. 79/10, s8(1)(b)
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.

Findings:
1. The home has a medication administration policy and procedure in place to direct registered staff administration of medication and treatment to the residents. The policy was not complied

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

with by the home's registered staff during the administration of medication.

2. The medication pass in 2 dining rooms was observed at various meal periods. It was noted that residents received their medications simultaneously by the registered staff without referring to the Medication Administration Record book to reference correct medication for correct resident, and ingestion of medications were not supervised. Other resident's medications were left at tables and ingestion of medication was not supervised.
3. Medications were administered to identified residents with the MAR open to the page for other residents.

VPC – pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring that a home's policy and procedure that is in place is complied with, to be implemented voluntarily

Inspector ID# - 141 and #173

WN #9: The Licensee has failed to comply with LTCHA 2007, S.O 2007, c. 8, s3(1)8 Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. Registered nurses were observed testing resident's blood sugar levels and administering insulin to multiple residents in the hallway in front of other residents, staff and visitors. The staff did not afford these residents privacy during treatment procedures.

VPC – pursuant to LTCHA, 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 every resident s right to be afforded privacy in treatment and in caring for his or her personal needs is respected and promoted, to be implemented voluntarily

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WN#10: The Licensee has failed to comply with LTCHA 2007, S.O 2007, c. 8, s129 (a)(2) Every Licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

Findings:
The following was observed during the inspection period:

1. Prescribed topical creams were left at the bedside with residents in bed. The resident's records did not indicate self medication.
2. Prescribed medications were found at the bedside unattended and on the handrail in common hallway of the home

VPC – pursuant to LTCHA, 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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily

Inspector ID# - 141 and #173

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** January 7, 2011