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
Aug 14, 2014	2014_248214_0022	H-000808-13;H-000950-13	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 - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

CATHY FEDIASH (214)

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): August 11, 12, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Administration, Director of Care (DOC), Environmental Services Supervisor, Registered Staff, front line nursing staff.

During the course of the inspection, the inspector(s) reviewed clinical records, critical incident report, investigative notes, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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. 30. General requirements

Specifically failed to comply with the following:

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #200's clinical record as well as the submitted critical incident from the home indicated that on an identified date in December 2013, the resident had eloped from the home and was found nearby, approximately 15 minutes later, outside of the home. Investigative notes completed by the manager on-call at the time, indicated that the registered staff informed the manager on-call that the resident was "muddy" from a fall and had been transported back to the home by car. A review of the resident's clinical record indicated that the resident's fall and their transportation back to the home by car, had not been documented in the resident's clinical record. This was confirmed by the DOC and the Director of Administration. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: 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:

s. 6. (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/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #200's clinical record including their plan of care indicated that the resident was a high risk for falls and required a wheelchair alarm to be applied when the resident was up in their wheelchair; and that the resident was to have hourly safety checks completed, as a result of an elopement from the home.

A) On an identified date in August 2014, resident #200 was observed sitting in the hallway in their wheelchair. Upon further observation, it was identified that the wheelchair alarm had not been applied. An interview with front line nursing staff and registered staff confirmed that a wheelchair alarm was to be applied and had not been.

B) A review of resident #200's clinical record indicated that staff were required to perform and document hourly safety checks in the Point of Care (POC) electronic record. A review of the resident's POC electronic record indicated that on an identified date in December 2013, the day of implementation of the hourly safety checks, the resident was scheduled to have hourly safety checks commence at 0030 hours and hourly thereafter. The POC hourly safety checks indicated that the resident was not checked until 0312 hours. A review of the hourly safety checks for the day and evening shift on this same day, indicated that hourly safety checks that were scheduled to commence at 1530 hours had not been completed until 2203 hours. A review of the hourly safety check intervention which remains current in the residents plan of care indicated that on an identified date in August 2014, hourly safety checks scheduled to commence at 1830 hours had not been completed until 2150 hours. An interview with the DOC and Administrator confirmed that the resident had not been checked hourly as specified in their plan of care. [s. 6. (7)]

WN #3: 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 did not ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home's policy, Falls Prevention Program (V3-630 and dated August 2013), indicated that once a resident has fallen, the registered staff will immediately:

- Notify the physician immediately and orders carried out

- Document the initial physical assessment; and complete and document a head to toe physical assessment at least q (every) shift x 3 days following a fall

- Lead a Post Falls Huddle – which will be completed by the registered nurse in collaboration with the front line staff. The purpose of the post fall huddle is to identify the root cause of the fall, look for contributing factors and trends, and identify interventions that can mitigate future risk. The post falls huddle document is completed in the electronic health record

A) A review of resident #100's clinical record as well as the submitted critical incident from the home indicated that the resident sustained an unwitnessed fall on an identified date in November 2013. The following day, the resident was transferred to hospital for complaints of discomfort. The resident was transferred back from the hospital to the home, later that evening. A review of the resident's clinical record identified that the physician had not been notified immediately of the resident's fall and that registered staff had not completed and documented a head to toe physical assessment at least every shift for three days following the resident's fall, as required by the home's policy. This was confirmed by the DOC.

B) A review of resident #200's clinical record as well as the submitted critical incident from the home indicated that on an identified date in December 2013, the resident had eloped from the home and was found nearby, approximately 15 minutes later, outside of the home. Investigative notes completed by the manager on-call at the time, indicated that the resident had fallen during the elopement. A review of the resident's clinical record identified that a post fall huddle had not been completed for this resident's fall and that registered staff had not completed and documented a head to toe physical assessment at least every shift for three days following the resident's fall, as required by the home's policy. This was confirmed by the DOC and the Director of Administration. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #200's clinical record as well as the submitted critical incident from the home indicated that on an identified date in December 2013, the resident had eloped from the home and was found nearby, approximately 15 minutes later, outside of the home. Investigative notes completed by the manager on-call at the time, indicated that the resident had fallen during the elopement. A review of the resident's clinical record identified that a post-fall assessment had not been conducted using a clinically appropriate assessment, specifically designed for falls. This was confirmed by the DOC and the Director of Administration. [s. 49. (2)]

Issued on this 14th day of August, 2014

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