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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 2, 2015	2015_371193_0004	T-1963-15	Follow up

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - CREEDAN VALLEY
143 MARY STREET CREEMORE ON L0M 1G0

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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 18, 19, 23, 2015.

The inspector reviewed residents' health records and the home's relevant policies and procedures, observed the provision of care and staff-residents interactions.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers, registered nurses, activations staff, physiotherapist, Director of Care (DOC), the Administrator and the acting Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #003	2014_171155_0027	193
O.Reg 79/10 s. 110. (2)	CO #005	2014_171155_0027	193
O.Reg 79/10 s. 131. (2)	CO #004	2014_171155_0027	193
O.Reg 79/10 s. 131. (3)	CO #006	2014_171155_0027	193
O.Reg 79/10 s. 131. (4)	CO #007	2014_171155_0027	193
O.Reg 79/10 s. 131. (5)	CO #008	2014_171155_0027	193
O.Reg 79/10 s. 8. (1)	CO #002	2014_171155_0027	193

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 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 has failed to ensure that the care set out in the plan of care was provided to 11 residents, resident #5 to #15, as specified in their plans of care.
On March 18, 2015, the noon medication pass was observed on Trillium Way from 12:25 pm until 2 pm. The medication administration started at the nursing station and continued in the dining room. At 2 pm there were 11 residents who did not receive various medications scheduled for 12 pm. Review of the plans of care indicated that pain medication, anticonvulsants, diabetic medication, vitamins and dietary supplements were scheduled to be administered for these residents at 12 pm.
The registered nurse indicated these residents will receive their 12 pm prescribed medications later, after all other residents leave the dining room. The nurse further stated that she can not leave the dining room until the last resident leaves it as per the home's policy.
The electronic medication administration record (eMAR) review revealed the identified residents were scheduled to receive medications at 12 pm, however, they received the medications two and a half to three hours later and this was not an isolated incident as the 8 am medication on the same day was given with the same delay.
The home's policy Medication administration, number V3-890, revised on April 2013, states and interview with the DOC confirmed the expectation for medication to be administered within one hour as per the College of Nurses of Ontario best practices for the prescribed time of administration. She also indicated that the expectation for the nurse is to inform the charge nurse or the DOC when a delay is anticipated and residents are to receive their medication in a timely manner. The DOC indicated that the home does not have a policy that requires a nurse to be at all times in the dining room at meal times. [s. 6. (7)]

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 the care set out in the plan of care in relation to the medication administration as per schedule, is provided to residents as specified in their plans of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act was fully respected.
The inspector observed during the inspection the eMAR screen left open with residents' personal health information visible to passers by on three occasions:
- on March 23, 2015, at 1 pm on Trillium Way
- on March 18, 2015, at 12:25 pm and 12:40 pm on Poppy Lane.
Interview with the DOC confirmed that the home's expectation is to have the screen closed when the nurse is not in attendance. [s. 3. (1) 11.]

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 has failed to ensure that the policy Medication management-resident self-administration, number V3-1050, revised on March 2012, and Medication administration, number V3-890, revised on April 2013, were complied with.
The first policy requires for the nurse and/or consultant pharmacist to assess the resident's capability to understand the use, the need, the potential side effects, the need for monitoring and documentation of the use of the drug, and the importance of keeping the drug safe and secure. This assessment is to be completed when the order is given, every three months, with the resident's quarterly review, and with a change in the resident's condition.
The second policy requires the registered nursing staff to complete the electronic documentation on eMAR after the medication has been administered.
Resident # 5's record review indicated the resident can self-administer three different medications; however, resident's self-administration assessments were not completed as required by the home's policy for neither of the drugs prescribed.
The eMAR indicated the resident can self-administer, however, the administration was not documented for any of them.
Resident interview indicated that he/she self-administered the three medications as needed and he/she did not inform the nurse when the drugs were used as nobody asked the resident.
Record review and DOC interview confirmed the resident's assessments for self-administering were not completed for any of the three medications that the resident has orders to self-administer. Also, there was no documentation for the medication administered by the resident. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.
Review of the licensee's Medication management policies indicated they are approved by the VP- Quality, Risk and Clinical Innovations. This was confirmed by the DOC and the acting Administrator. [s. 114. (3) (b)]

Issued on this 2nd day of April, 2015

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

Original report signed by the inspector.