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
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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
Aug 14, 15, 16, 17, 21, 22, 2012	2012_031194_0038	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 - ELLESMERE
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC)Assistant Director of Care (ADOC), Environmental Manager, Dietary Manager,Registered Practical Nurse (RPN),Physio Assistant, Personal Support Worker(PSW), Housekeeper,Substitute Decision Maker (SDM)for resident # 001 and residents.

During the course of the inspection, the inspector(s) Observed residents, reviewed clinical health records, and relevant policies

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 VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to comply with O. Reg s.6(7) when care set out in the plan of care for resident #001 was not provided as specified in the plan.

The plan of care for resident #001 directs staff to trim and or clean nails every first shower of the week by Registered staff.

Policy at the home is for Registered staff to perform any nail care required for specifically identified residents.

Interview with RPN verifies that nail care is done by the Registered staff on the unit. RPN states that tasks is documented in the progress notes once completed.

SDM has expressed concerns to the licensee that nail care is not being completed for Resident #001

Progress notes reviewed for resident #001 indicate that nail care was only provided for resident #001 once per month, for two identified months.

Nail care as set out in the plan of care for resident #001 was not provided as indicated in the resident's progress notes, for two months.

Progress notes for resident #001 indicate that "Medications are to be given when SDM is around as requested".

RPN confirms that she administered an identified medication without the SDM being present.

The SDM was not present for medication administration as set out in the plan of care.
2. The licensee failed to comply with LTCHA, 2007 s.6(5) when SDM for resident #001 was not given the opportunity to participate fully in the development and implementation of the resident's plan of care when not notified prior to treatment being provided.

A Care conference was held with SDM and interdisciplinary team. It was stated at this meeting that the SDM was to be notified and present when any treatment was done for resident #001.

Progress notes indicate that SDM was upset when a treatment was attempted for resident #001. SDM was not aware that a treatment had been ordered. RPN charts that, writer is not aware and I told SDM that if that is the preference to ask for approval first, then writer will have to take note of that and inform other staff"

SDM was not given the opportunity to participate in the development and implementation of the plan of care when not informed of treatment being provided for resident #001, as requested in previous care conference.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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 comply with O.Reg 131(2) when medications for resident #001 were not administered in accordance with the directions for use specified by the prescriber.

A physician's order for an identified medication was received for resident #001

Resident #001's, Medication Administration Records(MAR)were reviewed by the inspector and there is no indication that the identified medication was administered to the resident.

Interview with RPN on the unit stated that she does not remember if she administered medication.

Progress notes for resident #001 were reviewed by inspector. There is no documentation to support that the identified medication was administered to resident #001 .

SDM has expressed concerns to the licensee, that the identified medication was not administered.

2. Resident #001 returned from hospital on an identified date.

The Medication Administration Records indicates that two identified medications were not administered to the resident, the day after return from hospital, as they were not available.

Progress notes for resident #001 indicate that the identified medication was not given to resident #001 as it was not available, and that RPN phoned Classic pharmacy to send the medication that evening.

3. On another identified date, resident # 001 returned from hospital. Resident #001's medication were not confirmed by physician in time to ensure "same day delivery" by the pharmacy provider. The registered staff did not access the back up pharmacy to ensure the medication would be available for the resident #001 the following day. The identified medication was not given to resident #001, as it was not available at the home.

DOC confirms that the home failed to access the back up pharmacy for the identified medication for resident #001, resulting in the medication for resident #001 not being available the following day.

Issued on this 22nd day of August, 2012

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

Chantal Lafreniere (194)