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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2015	2014_297558_0021	T-1142-14	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 - NORFINCH
22 NORFINCH DRIVE NORTH YORK ON M3N 1X1

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

BARBARA PARISOTTO (558), NATASHA JONES (591), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 3, 4, 5, 2014, and February 17, 2015.

During the course of the inspection, the inspector(s) spoke with the office manager, the physiotherapist (PT), the registered dietitian (RD), the dietary manager (DM), the food service supervisor (FSS), registered nurses, registered practical nurses, personal service workers, the hair dresser and a family member.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

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

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

Resident #1 was at nutritional risk related to dementia affecting poor intake and significant weight loss.

Record review and interview with the family member revealed a concern that there were days that the resident did not receive his/her nutritional supplement. The resident was prescribed a nutritional supplement ordered on a specified date.

Interview with the DM revealed that during a later specified period of time the resident’s nutritional supplement was discontinued.

Interview with the RD revealed that the resident’s nutritional supplement was not discontinued.

A review of the RD/FSM/nursing communication tool indicated to discontinue previous orders for labeled snacks. The DM indicated that it was understood that labeled snacks included labeled supplements. The RD clarified that nutritional supplements are not considered a labeled snack.

The DM failed to collaborate with the RD regarding the provision of a nutritional supplement for resident #1. [s. 6. (4) (b)]

2. A record review revealed that resident #1 experienced gradual weight loss of 4.2kg over a specified period of time. A nursing progress note indicated the "writer to inform staff as dietitian has already noted that resident has lost weight since admission and resident has also started refusing meals".

Interview with the RD could not confirm that a discussion with the registered staff occurred.

Record review and interviews with staff revealed that a referral was not sent for a nutritional assessment.

Interview with the registered staff and family member revealed that the family addressed concerns related to resident's change in condition, including intake, weight and requested dietary supplements.

The registered staff indicated as per the family's request, a referral was sent to the RD to assess the resident's poor food intake, request for dietary supplement, and weight. [s. 6. (4) (b)]

3. The licensee has failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

An interview with the business manager revealed that consent was obtained to provide a haircut every two months to resident #1 effective September 6, 2013. Services were rendered on September 12, 2013, and January 30, 2014.

Based on the consent, hair dressing services in November 2013 and March 2014 would have been expected.

An interview with an RN revealed resident #1 refused hair dressing services over a period of time and missed a couple of appointments. The resident's refusals were not documented.

An interview with the hair dresser confirmed hair dressing services were not rendered in November 2013 or March 2014. [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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

Issued on this 20th day of February, 2015

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

Original report signed by the inspector.