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
Performance Improvement and Compliance Branch
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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
Oct 17, 18, 19, Dec 1, 5, 6, 12, 2011	2011_056158_0014	Critical Incident

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 - NORTH BAY
401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), restorative aides, several residents and family members.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, the home's Falls Prevention and Management program, the home's medication policy V3-1230, V3-890 as it relates to the processing of physicians' orders and the medication administration, and observed resident care.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Hospitalization and Death

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. A resident's nutritional care plan identified the following:
"total assistance, ensure resident receives the therapeutic diet; staff to sit with resident, encourage resident to eat the entire meal and drink adequate fluids, and specific textured diet.".
A swallowing assessment was completed by the Speech Language Pathologist (SLP). The interventions recommended by the SLP were not identified in the resident's plan of care.
The plan of care did not provide clear direction to staff and others who provide direct care to resident.
[LTCHA 2007, c. 8, s. 6 (1)(c)]
2. A resident was started on a treatment, however, the resident's POA was not informed of this added treatment.
The licensee failed to ensure that the resident's substitute decision maker was given the opportunity to participate in the development and implementation of the resident's plan of care.
[LTCHA 2007, c. 8, s. 6 (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On Oct.17/11 at 1600, a lingering urine odour was noted in the hallway outside two resident's rooms. On Oct 18/11 at 1530, a lingering urine odour was noted in this same hallway. [O Reg 79/10, s. 87 (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. A critical incident regarding the unexpected death of a resident was reported to the Director four days after the death of the resident.
The resident had fallen in the home during the evening and was being monitored as per the home's routine. The resident was found deceased seven hours later. The resident's unexpected death was not reported to the Director immediately in as much detail as is possible in the circumstances.
[O Reg 79/10, s. 107 (1)(2)]

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 subsections:

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
(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 policy titled "Physician's orders-processing" V3-1230 was implemented. Policy V3-1230 identifies that "at least 2 Registered staff will check the processing/transcribing of all Physician's orders, including the Quarterly Medication Reviews. Each Registered staff shall sign; identifying the date and time when he/she has processed or checked the processing of the order. The signature indicates that each Registered staff has checked the order and agrees that the order has been transcribed correctly and accurately".
A resident's physician's orders were reviewed by the inspector on Oct.17/11. Two of the resident's physician's orders to discontinue medication and one change in the resident's medication had one registered staff signature written.
A second resident's physician order for a safety positioning device and a bronchodilator did not have any registered staff's signatures written.
Two RN's and a RPN confirmed on Oct 18/11 that "two signatures are required when the orders are processed".
[O Reg 79/10, s. 114 (3)(a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

A narcotic analgesic was re-ordered for a resident's pain management by the physician on the resident's quarterly medication review.
The analgesic was documented on the resident's medication administration record (MAR) as administered on five different days. The effectiveness of the medication was not documented.
The resident's progress notes were reviewed by the inspector. A narcotic analgesic and a non narcotic analgesic administered by a RPN were documented, however, the effectiveness of the drugs were not documented.
Two RPNs confirmed that the response or the effectiveness of an analagsic is to be documented on the MAR and in the resident's progress notes.
The licensee failed to ensure that the resident's response to a drug and the effectiveness of the drug was documented.
[O Reg 79/10, s. 134 (a)]

Issued on this 15th day of December, 2011

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