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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 4, 2013	2012_162109_0012	T2712-11 T535-12	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 - O'CONNOR COURT
1800 O'Connor Drive, East York, ON, M4A-1W7

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

SUSAN SQUIRES (109)

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 19, 2012 and January 3, 2012

This inspection corresponds with Log # T 2712-11 and T535-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Personal Support Workers, Registered Nursing Staff.

During the course of the inspection, the inspector(s) Observed the care of an identified resident, reviewed the health record of an identified resident

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Personal Support Services

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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
Resident # 1 was experiencing dental pain and was booked to see a dentist. On October 27, 2011 the Dentist saw the resident and ordered an antibiotic and scheduled her for a tooth extraction to be done on November 9, 2011. The dentist also requested that the INR be normalized prior to dental surgery.
On October 31, 2011 a physician communicated to the family that the Coumadin should be held for at least 5 days for the INR levels to normalize.
On November 1, 2011 a physician placed the Coumadin on hold until after dental surgery.
The home's process for communicating with the physician was not followed.
According to the licensee, if the Coumadin is on hold, it is up to the nurse to identify this and communicate this to the physician during the order processing activity.
On November 4, 2011 an RN phoned the physician with the INR results and the Coumadin was re-started and subsequently administered to the resident.
On November 8, 2011 the family member of the resident raised concerns with the home that the Coumadin was restarted without notifying the family and was being given to the resident prior to the dental surgery.
On November 8, 2011 The Coumadin was the placed back on hold by the physician.
[s. 6. (4) (a)]

Issued on this 4th day of January, 2013

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