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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2013	2013_202165_0019	H-000809-13	Critical Incident System

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - OXFORD
263 WONHAM STREET SOUTH, INGERSOLL, ON, N5C-3P6

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 16, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker(PSW)

During the course of the inspection, the inspector(s) reviewed clinical health record, policies and procedures and observed care interventions

The following Inspection Protocols were used during this inspection:

Falls Prevention

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. (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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
Resident #001's high risk for falls plan of care directed staff to ensure the bed sensor was in place and in working order when laying down in bed. In October 2013, the resident had been laying in bed however; crawled out of bed to use the bathroom. The DOC confirmed that the bed alarm was not in working order at the time and did not alarm staff when the resident crawled out of bed. The resident was found on the bathroom floor by staff and was sent to hospital with injury. [s. 6. (7)]

2. The licensee did not ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.
A) The last print date for resident #001's high risk for falls plan of care that was accessible to all staff was April 2013. The only intervention indicated for PSW staff who provided direct care was to monitor the resident for 72 hours post fall. The computerized plan of care included interventions to promote exercise, ensure the bed sensor was in place and in working order when the resident was laying in bed, ensure the resident was wearing appropriate footwear and review information post falls to determine cause. Registered staff confirmed that PSW staff did not have access to the computerized plan of care which was last updated in September 2013, and confirmed that the plan of care accessible for staff who provide direct care was not updated with the current content of the resident's plan of care. [s. 6. (8)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.
A) The RPN reported that the residents health condition and care needs had recently changed. The resident previously used one side rail to transfer out of bed, they were able to use their walker and transfer themselves to the toilet however; the resident's health condition and care needs had recently changed. On October 16, 2013, at approximately 1005 hours the resident was observed in bed with both side rails in the up position. PSW staff confirmed that the resident used both side rails when in bed for safety. Staff reported that the resident used a chair alarm when up in their wheel chair as an intervention for the prevention of falls and this was observed by the inspector. The RPN confirmed that the residents current plan of care did not include recent changes in the residents care needs including interventions for safety and the use of side rails and interventions for the prevention of falls including a chair alarm. [s. 6(10)(b)]

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 be implemented voluntarily.

Issued on this 28th day of October, 2013

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

Tammy Szymanowski