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
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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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
Jun 28, 29, 30, 2011	2011_071159_0011	Complaint

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 - TULLAMORE
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

ASHA SEHGAL (159)

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 Assistant Director of Care, Administrator, Resident Assessment Instrument (RAI) coordinator, Food Service Manager, Director Of Care.

During the course of the inspection, the inspector(s) Interviewed Assistant Director of Care, Administrator, Food Service Manager and Resident Assessment Instrument(RAI) Coordinator. Reviewed resident's health record.

The following Inspection Protocols were used in part or in whole during this inspection:

Dignity, Choice and Privacy

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Definitions	Définitions
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 O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits sayants :

1. The Licensee did not ensure that residents with weight changes are assessed by the Registered dietitian using an interdisciplinary approach.
Identified resident had 14.2% weight loss over 2 month and was not assessed by the registered dietitian to address the weight loss.[O.Reg.79/10 s.69:2]

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 ensuring that residents with the weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following subsections:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits sayants :

1. The registered dietitian did not complete nutritional assessment for an identified resident when there was a significant change in resident's condition.
The progress note for resident indicated that the resident's general physical condition had deteriorated and had been eating poorly and refusing meals. Dietary referral was made to registered dietitian to assess resident for poor intake.

As evidenced by food and fluid intake records the resident was eating and drinking poorly. The progress notes stated that the Nurse Practitioner was called to assess resident. The Nurse Practitioner noticed resident was dehydrated and the resident had treatment initiated prior to resident transferred to hospital.

There was no evidence that the resident was assessed by the registered dietitian and the plan of care developed to address resident's risks associated with poor intake and dehydration prior to transfer of resident to hospital

The progress notes stated that the resident returned from the hospital with significant change in health status. Dietary referral was made for registered dietitian to assess resident nutritional needs including diet.

Documentation in the progress notes had identified concerns related to resident's poor oral nutrition and hydration intake and swallowing problem. A dietary referral was made and resident's diet texture was changed from regular to minced.

The Registered Nurse had documented in progress notes that resident was having trouble with minced texture diet and resident was put on a trial pureed texture and thickened fluids diet. The food service Manager was informed. The resident did not receive nutritional assessment by the registered dietitian in relation to chewing and swallowing ability.[O.Reg.79/10, s.26 (4)]

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 ensuring that the registered dietitian who is the member of the staff of the home:(a)complete nutrition assessment for the resident an admission and whenever there was a change in the resident's health status.(b) hydration status and any risks related to hydration , to be implemented voluntarily.

Issued on this 16th day of August, 2011

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