Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 27, 2010	2010_157_956_14Sep150609	Log #O-001118

Licensee/Titulaire
Leisureworld Caregiving Centre Altamont,
92 Island Road,
Scarborough, ON
M1C 2P5
Fax: 416-284-4781

Long-Term Care Home/Foyer de soins de longue durée
Vigour Limited Partnership on behalf of Vigour General Partner Inc.,
302 Town Centre Blvd.,
Suite #200,
Markham, ON
L3R 0E8
Fax: 905-415-7623

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

Pat Powers, #157
Caroline Tompkins, #166

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the care of a resident.

During the course of the inspection, the inspector spoke with the resident, the Administrator, Assistant Director of Care, one Registered Nurse (RN), one Registered Practical Nurse (RPN), the home's wound care nurse, the Enterostomal Therapy Nurse (ET Nurse) and several Personal Support Workers (PSW).

During the course of the inspection, the inspector observed the resident's room and bathroom, the resident's personal aids and personal items, the resident's nutritional care and support services during the breakfast and the noon meal, the home's policy for documentation of treatments, the resident's clinical health record.

The following Inspection Protocols were used during this inspection:
Fall Prevention Inspection Protocol
Personal Support Services Inspection Protocol
Skin and Wound Care Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres : travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de « exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10, Section 30(2), The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

1. The resident developed a wound and was assessed by the wound care nurse and the ET nurse. Treatment was documented and commenced.
2. Wound care interventions on several occasions in July, August and September were recorded in Medication Administration Record (MAR) as scheduled to be administered but were not recorded as having been administered.
3. The home's policies state that:
   - "Medications shall include medications and or treatments that are administered orally, topically, parentally and rectally".
   - Staff shall "chart all medications administered by signing your initials in the appropriate box corresponding to the correct medication, date and time on the MAR sheet." and further states that "Failure to chart a medication that has been given or not given is considered a medication error."

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s.15(2) Every licensee of a long-term care home shall ensure that, (a) the home, furnishings and equipment are kept clean and sanitary.

Findings:

On September 27, 2010, a resident's wheelchair was observed to have what appeared to be dried food on the wheels, seat and chrome frame.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Patricia A Harris
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). November 17. 2010