Ontario

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
Jun 6, 2014	2014_215123_0005	H-000345-13,H-000597-13	Critical Incident System

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON MEADOWS
215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5

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

MELODY GRAY (123)

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): May 22, 23, 26, & 27, 2014

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Staff members, the home management team members including the Director of Care (DOC) and the Associate Director of Care (ADOC)

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed residents' records, observed staff-resident interactions and observed equipment and supplies available in the home

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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 fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
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. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The home failed to ensure that the Director was 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 fire, unplanned evacuation or intake of evacuees. 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).

An identified resident #003 passed away unexpectedly in September, 2013 and the home did not immediately notify the Director as required. The home notified the Director two days later. The Director of Care (DOC) was interviewed and reported that they were not sure why incident was not reported to the Director as required.

The home failed to inform the Director immediately, in as much detail as is possible, followed by the report required under subsection (4) of an unexpected or sudden death. [s. 107. (1)]

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 ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of the following incidents in the home, followed by the report required under subsection (4): An unexpected or sudden death, including a death resulting from an accident of suicide, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The record of identified resident #003 was reviewed. The Physicians' Quarterly Medication Review for the period of August, 2013 to October, 2013 for resident #003 included the order for: a medication to be administered on a sliding scale multiple times daily based on the results of an identified test. The physician order indicated that the resident was to receive the medication as above if the test result was above a specific level and that the staff were to call the physician or administer none of the medication for results below that level.

In September, 2013 it was noted in the record of resident #003 that the resident's test results were above the level specified by the physician on seventeen occasions including at the time of two incidents in September, 2013. The resident's test result levels on this date was noted to be elevated on two occasions.

The resident's Medication Administration Record (MAR) for September, 2013 was reviewed and indicated that the resident received the medication on eight of seventeen times where the test results met the criteria indicated by the physician in the order for the medication.
There was no documentation in the MAR of the resident receiving any medication as per sliding scale on the date of the incidents related to the recorded elevated test results noted at the time of both incidents.

The resident's Progress Notes were reviewed and it was noted on the day of the incidents that the staff administered the medication as ordered by the physician at the time of the second incident. There was no documentation in the resident's Progress Notes of that day related to the administration of the medication as ordered by the physician for the recorded elevated test results during the first incident.

The Director Of Care (DOC), and registered staff members were interviewed and reported that the staff are expected to document in the Medication Administration Records when they administer medications to residents.
The resident was transferred to the hospital in September, 2013 and passed away the following day.

The home failed to ensure that all drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 to ensure that drugs all drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The home failed to ensure that the plan of care of an identified resident was based on an assessment of the resident and the resident's needs and preferences.

The plan of care of identified resident #001 was reviewed and it indicated that the resident required the assistance of two staff for bathing.

Personal Support Workers(PSW) were interviewed and reported that: The resident required the assistance of only one staff to shower and that the resident was able to shower independently if staff wheeled them into the shower and provided the supplies and assisted the resident when they completed their shower. Two staff members are required only for transferring the resident and for wheeling them in and out of the shower. The PSW also indicated that the resident frequently requested privacy and that the staff would remain in the shower room behind the curtain. The PSW reported that the resident used the seatbelt on the shower chair for safety and that the resident was able to open the seatbelt at times and preferred to take showers of up to 45 minutes as well.

The PSW reported that the resident was transferred to the shower chair and wheeled into the shower by two staff. They remained with the resident while the other PSW left and attended to other duties. The resident requested privacy and the PSW waited behind the curtain. The resident opened the seatbelt on their own. The PSW heard a noise and when they opened the curtain they found that the resident had fallen from the shower chair. The resident was transferred to hospital after the fall.

The plan of care for identified resident #001 was reviewed and it did not include information related to the resident's refusing staff assistance for showers and requesting to shower independently at times. The resident's plan of care also did not include information related to the resident taking long showers of up to 45 minutes; their requesting privacy while showering and the resident's need for using a seatbelt while in the shower chair.

The Associate Director of Care (ADOC) was interviewed and reported that all residents are individually assessed by the staff to determine their need for using a seatbelt on in the shower chair.

The home failed to ensure that resident's plan of care specific to bathing, was based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The plan of care for identified resident #003 was reviewed and it indicated that the resident's physician ordered that the resident's vital signs were to be taken twice daily.

The resident's Weights and Vitals Summary record for September, 2013 was reviewed. It indicated that the resident's pulse was recorded twelve times and once on the day of the incidents. There was no record of the resident's temperature noted for the month of September, 2013. The resident's blood pressure was recorded five times, including only one time on the day of the incidents. The resident's respiration was recorded one time which was on the day of the incident. The resident's Progress Notes including those for September, 2013 were reviewed and one temperature reading was noted related to one of the incidents of September, 2013. No other records of the resident's vital signs were noted.

The Director of Care (DOC), and registered staff members were interviewed and reported that after the first incident of September, 2013 the identified resident #003 was assessed and they were fine. The resident's vital signs were stable and they were not injured. After the second incident of the same date at there was a change noted in the resident's status and that appropriate action was taken.

The resident was transferred to hospital after the second incident in September, 2013 and passed away the following day.

The home failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

Issued on this 6th day of June, 2014

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