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

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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 9, 2013	2013_109153_0024	T-113-13	Complaint

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 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 - CREEDAN VALLEY
143 MARY STREET, CREEMORE, ON, L0M-1G0

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

LYNN PARSONS (153)

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): September 16, 18, 19, 2013.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care(ADOC), Registered Nurse(RN), MDS RAI Co-ordinator, and Personal Support Workers(PSW).

During the course of the inspection, the inspector(s) reviewed clinical health records, staff schedules and home policies including fall prevention program, head injury routine and prescribing resident orders.
Completed observations of the provision of resident care including the use of fall prevention items and 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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.
The clinical health record revealed that Resident #1 experienced fall incidents on two separate occasions.
The written plan of care from May 2, 2012 to March 6, 2013 did not provide clear directions regarding fall prevention strategies that were in place which included a personal safety alarm and floor mats beside the bed.
When interviewed staff confirmed a personal safety alarm and floor mats beside the bed were in place.
[s. 6. (1) (c)]

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any policy or procedure put in place is complied with.
The home's policy titled Head Injury Routine V3-680 dated March 2012 and March 2013 indicates under policy #1;
1. Head Injury Routine will be initiated on any resident who has sustained or is suspected of a sustained head injury; and after any unwitnessed resident fall.
Resident #1 was found lying on the floor mat beside the bed with the sensor alarm still attached to the resident.
Due to cognitive impairment Resident #1 was unable to communicate what had occurred and a Head Injury Routine was not initiated.
When interviewed the Director of Care confirmed a head injury routine should have been initiated.

The home's policy titled Prescribing Resident Orders V3-1230 dated September 2008 under the procedure section indicates all prescribing orders for medication include;
- order date
- resident name
- medication name, dosage, route, frequency
- purpose or therapeutic outcome expected from the medication
- duration of therapy if applicable
- prescribers name, signature and designation

The first registered nursing staff is responsible for;
- follow-up with the prescriber in a timely manner in the event the medication order is incomplete, unclear, inappropriate or misunderstood

A telephone order was received for Resident #1 to receive 2 to 4 mls of an identified medication intramuscularly or subcutaneously every 4 hours whenever necessary for pain.
The physician's order did not identify the dosage to be administered in relation to the strength of the identified medication supplied by the Pharmacy.
When interviewed the Director of Care confirmed the telephone order did not comply with the policy and the registered staff member should have contacted the physician for further clarification. [s. 8. (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 every policy and procedure is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the record of every former resident is kept at the home for at least the first year after the resident is discharged from the home.
The home was unable to provide the written plan of care for Resident #1 for the period from August 3, 2012 to March 6, 2013 related to fall prevention.
Resident #1 was discharged from the home in March 2013.
When interviewed the Director of Care confirmed the written plan of care was unable to be located. [s. 233. (2)]

Issued on this 25th day of October, 2013

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

Lynn Parsons