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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Oct 25, 26, 30, 31, Nov 7, 8, 2012	2012_109153_0026	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 - MUSKOKA
200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3

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.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Registered Nurse(RN), Registered Practical Nurse(RPN), Personal Support Workers(PSWs), Resident and Substitute Decision-Maker(SDM).

During the course of the inspection, the inspector(s) Reviewed clinical health records and home policies related to skin and wound management and pain management.
Observed resident care and staff to resident interactions.

The following LOG was inspected as part of this Inspection: T-703-12.

The following Inspection Protocols were used during this inspection:

Pain

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(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 the resident was reassessed when the resident's care needs changed.
Resident #1 was not reassessed when the resident's left knee pain increased and was not relieved by Tylenol 650mg orally 4 times a day on February 25, 2012 until the substitute decision-maker requested further assessment by a physician.
The physician examined the resident and determined the increase of pain in the left knee was due to gout.Dilaudid 1mg orally every 4 hours when required was prescribed to manage the increased level of pain.
Staff did not reassess the resident's change in pain status or implement any measures to alleviate the increased pain.
Interview with Administrator confirmed an RPN should have reassessed the resident's pain and informed an RN who would have completed an assessment and notified the physician to obtain new orders for pain control.[s.6(10)(b)]
2. The licensee did not ensure the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
The substitute decision-maker for Resident #1 was not given the opportunity to participate in the development and implementation of the resident's plan of care when the resident developed a skin condition. Interviews with staff confirmed the substitute decision-maker should have been notified when Resident #1's condition changed to facilitate participation in the development and implementation of the plan of care to address the change in condition.[s.6(5)]
3. The licensee did not ensure the resident is reassessed when the resident's care needs change.
Following dinner on March 14, 2012, a PSW informed a RPN that Resident #1 had a rash.
The RPN visited the resident and noted several reddened raised areas on the right shoulder and neck area which the resident indicated were sore. No further action was taken and there was no communication to the nursing staff on the following shift.
The resident was transferred to the local hospital for an investigative procedure the following day. Upon return from hospital the substitute decision-maker requested further assessment by a physician. The home's physician examined the resident and diagnosed the skin condition as contagious. Infection control procedures were implemented.[s.6(10)(b)]
4. The licensee did not ensure the care set out in the plan of care was provided to the resident as specified in the plan.
On the afternoon of March 15, 2012, a holter monitor was applied to Resident #1 at the local acute care hospital.
The holter monitor was prescribed by the home's physician to monitor the resident's cardiac function on a continuous basis over a 3 day period.
The substitute decision-maker visited Resident #1 after dinner on March 15, 2012 and found the holter monitor in a drawer and not attached to the cognitively impaired resident as ordered.
The nursing staff on the afternoon shift were unaware the resident had a holter monitor in place and were not monitoring to ensure the monitor remained in place on a continuous basis.
The resident did not receive the care as set out in the plan of care.
[s.6(7)]

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 resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident is reassessed when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure the resident's written record is kept up to date at all times.
Resident #1 was diagnosed with a right eye infection and prescribed antibiotic eye drops.
A review of the Medication Administration Records for February and March 2012 for Resident #1 indicates the prescribed medication was recorded as received 18 out of the 20 required doses.
There is no documentation to confirm the resident received the remaining 2 doses.
Inspector was unable to confirm through interviews that the resident received the prescribed medication as ordered.
The documentation was not kept up to date.[s.231(b)]

Issued on this 13th day of November, 2012

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

Lynn Parsons