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 15, 2013	2013_219211_0020	T-406-13	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - ST GEORGE
225 ST. GEORGE STREET, TORONTO, ON, M5R-2M2

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

JOELLE TAILLEFER (211)

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): August 7, 8, 9, 13, 14, 15, 2013.

During the course of the inspection, the inspector(s) spoke with Director of Administration, Director of Care, Nurse Manager, Administrative Manager, Occupational Therapist, Community Care Access Centre Coordinator, Registered staff, Personal Support Workers, Registered Dietitians, Supervisor Food Service, Residents, Resident Council's secretary, and resident's family member.

During the course of the inspection, the inspector(s) observed provision of care for residents, reviewed clinical records, reviewed the home policy on Enteral Feeding, reviewed Long-Term Care Home Accommodation and Unfunded Services Agreement.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Medication

Nutrition and Hydration

Skin and Wound Care

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

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. Resident #1 has been assessed and the plan of care revised by the Registered Dietitian on an identified date on July, 2013. The progress notes and the plan of care indicates that resident #1 is to receive Enteral Feeding at a identified rate for 24 hours to deliver the target volume of 1080 ml.

On August 8, 2013, an interview with the Registered Dietitian revealed that the rate and total amount of Enteral Feeding does not account for the times when the resident receives care requiring the Enteral Feeding to be stopped. Furthermore, the Enteral Feeding procedure indicates that if a medication needs to be administered through the feeding tube, the feeding needs to be held for approximately 15 to 30 minutes and flush with 20 to 30 ml of water before and after the delivery of medications.
Clinical review indicates that resident # 1 did not received the required amount of Enteral Feeding on an identified date in July, 2013 and four identified dates in August 2013. On these days, resident #1 received 989 ml, 960 ml, 947 ml, 980 ml, and 640 ml respectively. The information was confirmed on August 20, 2013 by the Registered Dietitian. [s. 6. (7)]

2. The licensee failed to ensure that the Enteral Feeding provided to resident #1 was documented on the intake record for 3 night shifts in July 2013 and 2 night shifts in August 2013, one day and evening shift in July 2013, one evening shift in August 2013 and all shifts on an identified date in July 2013. Staff interviews and clinical review indicates that the feed provided during those days was not completely documented. [s. 6. (9) 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 provision of the care set out in the care plan is documented, to be implemented voluntarily.

Issued on this 16th day of October, 2013

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