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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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 11,12,13,2011	2011-173-963-11Jan115241	H03063 Complaint H03121 CIS H03042 CIS H02832 Complaint

Licensee/Titulaire
Vigour Limited Partnership of behalf of Vigour General
302 Town Centre Blvd, Suite 200, Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée
Leisureworld Caregiving Centre – Tullamore
133 Kennedy Road South, Brampton, ON L6W 3G3

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – LTC Inspector – Nursing - #173

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two complaint inspections and two Critical incident reviews.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Assistant Director of Care, registered and non - registered staff and residents.

During the course of the inspection, the inspector: Observed resident care, reviewed policy and procedure, reviewed clinical health records

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control Inspection Protocol
Medication Inspection Protocol
Falls Prevention Inspection Protocol
Personal Support Services Inspection Protocols:

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

6 WN
6 VPC

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 LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out
(c) clear direction to staff and others who provide direct care to the resident.

Findings:

1. Plan of care for two residents did not set out clear direction to staff who provide direct care to the resident in relation to care needs identified.

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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 develop a process to ensure that there is a written plan of care for each resident that sets out clear direction to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(10)(c)
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
(c) care set out in the plan has not been effective.

Findings:

1. During this inspection, it was noted that one identified resident who had sustained a numbers of falls, was not reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective to prevent falls.

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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 related to developing a process to ensure the each resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s.8(1)(b)
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
(b) is complied with.

Findings:

1. **Home Policy # V3-890 Medication Administration was not complied with in relation to the following:**
   - **Identify resident by name and the home's identification process.**
   - **Read the medication label three times before administering the medication to the resident: (1) Read the label before pouring the medication; (2) compare the medication label with the order on the Medication Administration Record, (3) read the label after pouring the medication.**
2. **The staff of the home has not followed their Medication Administration Policy in relation to the following:**
3. A resident was noted to receive the wrong medications as a result of the homes medication administration policy not being followed.

4. **Home Policy V3-611 Falls Prevention –Falls Incident Investigation Policy indicates:**
   - **All incidents of resident falls are investigated, and measures put into place to prevent further incidence.**
   - **Investigate all incidents of falls (such as the attached example "Appendix A"), including but not limited to: other contributing factors which led to the resident sustaining a fall.**
   - **The plan of care shall be updated as appropriate**
5. **The staff of the home has not followed the Falls Prevention Policy in relation to the following:**
6. Two residents identified as having sustained falls in the home, did not receive a post falls assessment that included identifying contributing factors and implementing measures to prevent further falls as per the homes policy

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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 related to developing a process to ensure that where the home is required to have any plan, policy, protocol, procedure, strategy or system, that it is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)
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
(b) the residents care needs change or care set out in the plan is no longer necessary.

Findings:

1. One identified resident was not reassessed and the plan of care revised when the care needs of the resident continued to change and decline.

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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 related to developing a process to ensure that the resident is reassessed and the plan of care reviewed when the residents care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(7)
(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.

Findings:

1. One identified resident did not receive care set out in the plan of care as ordered by the Registered Dietician.

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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 develop a process to ensure that every resident receives care as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s107(5)
The licensee shall ensure that the residents substitute decision maker, if any, or any other person designated by the substitute decision maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Findings:

1. The Substitute Decision maker for one identified resident was not notified of a change in condition by staff at the home. The resident presented with symptoms over a 30 hour period that were not communicated to the family.

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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 related to developing a process to ensure that every resident or SDM is to be notified of a serious injury or illness in accordance provided by the person or person who are to be so notified, to be implemented voluntarily.

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. Lisa Wulff
Title: Date:	Date of Report: (if different from date(s) of inspection). June 20/11