Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére 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

Division de la responsabilisation et de la performance du système de santé
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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
Jan 11, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, Feb 1, 2, 3, 7, 8, 9, 21, 22, 24, 2012	2012_065169_0001	Complaint

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
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 ou des inspecteurs

YVONNE WALTON (169), BERNADETTE SUSNIK (120), MICHELLE WARRENER (107)

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 the Administrator, Director of Care (DOC), Assistant DOC, Regional Director, RAI (Resident Assessment Instrument) co-ordinator, Restorative Care Manager, Medical physician, nursing staff, administrative staff, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed the home's policies and procedures and observed care provided in multiple care areas.
This inspection references log numbers: H-00156, H-002510, H-01626, H-002436, H-02042.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Admission Process

Dining Observation

Food Quality

Hospitalization and Death

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure the policy titled, "Physician Orders-Processing" V3-1230 was complied with. The policy stated to process and check all physician orders within 8 hours of receipt of the order. The second check by Registered staff shall occur within 16 hours of receipt of the order.

An identified resident received an order from the physician for a specific medication. The registered nursing staff did not process the order until 3 days later, resulting in the resident missing 3 doses of the medication. The nursing staff confirmed this was missed. The medication sheets confirmed the medication was not provided.

An identified resident received an order from the physician and the registered nursing staff did not process the order for 28 days. The nursing staff confirmed this was not completed according to the home's policy. The doctors order sheet confirmed the dates of processing of the order.

An identified resident received an order from the physician for a medication. The registered nursing staff processed the order , however the registered nursing staff did not check the order for 3 days. The nursing staff confirmed this was not completed according to the home's policy. The doctors order sheet confirmed the dates of processing of the order.

2. The licensee did not ensure the policy titled, "Skin Care Program" V3-1400 was complied with. The policy stated to complete a weekly skin assessment for residents with altered skin integrity. An identified resident had altered skin integrity and the nursing staff did not complete a documented weekly skin assessment. The nursing staff and documentation in the clinical record confirmed this has not been completed.

3. The licensee did not ensure the policy titled, "Consent for Care and Treatment" V3-390, was complied with. Section 15 of the policy states "the appropriate health practitioner will obtain consent for treatment." An identified resident was started on a new medication and consent to treatment was not obtained from the resident's substitute decision makers. This was confirmed by the physician who ordered it, the nursing staff who transcribed the order, the nursing staff who administered the medication and the Power of Attorney for Personal Care. The medication administration record confirmed the medication was provided.

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 that ensures 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 is complied with., 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 subsections:

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 did not ensure that a medication was administered to an identified resident in accordance with the directions for use, by the physician. The doctor provided a new order for the medication to be administered, however the nursing staff did not process the order resulting in the resident missing 3 doses of the medication.

These omissions were confirmed by the nursing staff and confirmed on the medication administration record.

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 that ensures 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The clinical record was reviewed and it indicated a period of 4 weeks without reassessment. A referral was made to the wound and skin nurse, however the assessment by the wound and skin nurse was never completed. Nursing staff and the Director of Care also confirmed the lack of reassessment.

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 that ensures every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. A Personal Support Worker (PSW) was verbally abusive toward an identified resident and made a verbally abusive comment toward the resident regarding their care requirements.
The incident occurred and was reported to the management team. A Critical Incident report was not submitted to the Director within the timeframe required by legislation.
The Administrator and Director confirmed they had not submitted the critical incident to the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. An identified resident was not protected from verbal abuse by the staff. The resident reported that a PSW staff member spoke to them in a non dignified way about the resident's care requirements. The resident expressed feeling insulted, intimidated and humiliated.

The management of the home investigated and confirmed the resident's account of the incident. Interview with Personal Support Worker confirmed they made the comment to the resident.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. A registered nurse (RN)was not on duty and in the building on the night shift on one night. A registered practical nurse was given the duty to work the night shift with access to an RN only available by telephone. The home exhausted their list of RNs to call to cover the vacant shift and did not have an emergency back-up plan.

Issued on this 24th day of February, 2012

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