



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
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
Feb 2, 3, 7, 13, 14, 15, 16, 17, 2012	2012_071159_0003	Critical Incident

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 - MISSISSAUGA
2250 HURONTARIO STREET, MISSISSAUGA, ON, L5B-1M8

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of care, Registered Nurse and Registered Practical Nurse staff.

During the course of the inspection, the inspector(s) interviewed Registered Nurse, Personal Support Service Worker, Director of Care, Resident Assessment Instrument(RAI) Coordinator, reviewed clinical health record and Policy and Procedure related to Falls prevention and Post Fall Assessment.

Log # H-002226-11

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



<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p>	<p>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.)</p>
<p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (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 plan of care for an identified resident was not reviewed and revised in relation to use of a Personal Assistance Service Device(PASD). The progress notes completed by registered staff at home dated January and February 2012, stated "resident in bed with two side rails up for safety", however, the plan of care indicated one side rail used for PASD. On February 7, 2012 resident was observed in room in bed with two full size bed rails raised. Staff interviewed and records reviewed confirmed the plan of care for identified resident did not include use of two bed side rails for safety.

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 a written plan of care for all other residents is reviewed when care needs change, 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 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 :



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1. The licensee did not ensure that the Falls Prevention Program policy and procedure was complied with for an identified resident.

It was reported that the resident sustained fall in 2011. A review of resident's health record and interviewed registered staff confirmed that a post fall huddle was not completed for the resident.

The home's Falls Prevention Program Policy [Vol.3-Resident care Jan.2011] states " when a resident has fallen, a post fall huddle and assessment is conducted by the interdisciplinary team and the document is kept in the resident's chart".

The missing document and the expectation that the documentation should be completed was confirmed by Registered Staff and the Director of Care.

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 licensee policies, protocols and procedures are complied with, to be implemented voluntarily.

Issued on this 23rd day of March, 2012

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

ABG Selva