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
Sep 29, 2014	2014_370162_0007	T-000133-14	Resident Quality Inspection

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 - ALTAMONT
92 ISLAND ROAD, SCARBOROUGH, ON, M1C-2P5

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

TIINA TRALMAN (162), SOFIA DASILVA (567), STELLA NG (507), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, September 2, 3, 4, 2014.

Inspectors Nitel Sheth (500) and Susan Semeredy (502) participated in this inspection.
This Resident Quality Inspection inspection occurred concurrently with inspections 2014_382596_0006/T-822-13/T-820-13, 2014_324567_0014/T-817-13/T-429-14/T-465-14/T-1019-14, and 2014_370162_0009/T-821-13.

During the course of the inspection, the inspector(s) spoke with the executive director, director of care, associate directors of care, director of resident programs, food services manager, environmental services manager, MDS RAI coordinator, registered staff, registered dietitian, recreation assistant, housekeeping staff, personal support workers, dietary aide, residents and family members.

During the course of the inspection, the inspector(s) conducted observations in the home and resident's areas, care delivery processes, meal service, reviewed the home's records, policies and procedures, reviewed minutes of the Family Council, Resident's Council and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Resident #31 is identified with impaired vision. Record review of the resident's written plan of care indicates to ensure appropriate aids are available to support the resident while participating in activities.

Interview with an identified personal support worker (PSW) confirmed that he/she is aware that the resident does not see well, and the resident does not wear glasses. In addition, the identified PSW revealed that he/she does not know what are the 'appropriate aids' for resident #31's impaired vision.

Interview with the director of care (DOC) confirmed that appropriate aids are not

specifically identified in the written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On August 26, 2014, the inspector observed resident #19 in bed with altered skin integrity on identified areas.

Interview with an identified PSW, revealed that during care of the resident, soap and water is used to cleanse the resident's skin after each episode of incontinence, and that no other special interventions are required by the PSW staff related to the resident's wound care.

The ADOC confirmed that PSW staff are to use identified treatment products on resident #19 after each incontinent episode, in accordance with the Kardex and care plan directions. Interview with the DOC confirmed that all PSW's are expected to review and be familiar with all resident Kardex information located in Point of Care. [s. 6. (7)]

3. Resident #36 is at nutrition risk for swallowing problems and receives texture-modified foods and thickened fluid of an identified consistency.

On August 27, 2014, during an identified meal, the inspector observed that the resident was served and consumed a regular consistency beverage contrary to the resident's plan of care requiring thickened fluid of an identified consistency. As well, the resident was served and consumed regular soup contrary to the plan of care which indicates thickened soup of an identified consistency.

Interview with the registered dietitian (RD) revealed that the resident is to be provided the fluid consistency in accordance with resident #36's plan of care due to the associated swallowing risks. [s. 6. (7)]

4. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Record review revealed that resident #32 is identified at risk for falls, and the resident's written plan of care indicates that the resident uses an identified transfer aid during transfers.

Interview with the resident revealed that he/she uses the identified transfer aid when transferring from the bed to the chair, and the chair to the bed.

Interview with an identified PSW, confirmed that the resident can perform self transfer, and does not use an identified transfer aid.

Interview with an identified registered staff confirmed that the resident can perform self transfer independently at times, and that the resident is encouraged to ask for assistance for transfer to reduce the risk for falls. [s. 6. (8)]

5. Record review revealed that resident #35 is incontinent of bladder and bowel, and that he/she wears continence care products. The written plan of care for resident #35 indicates that the staff is to toilet the resident routinely to reduce episodes of incontinence and to ensure dryness and comfort.

Interview with an identified registered staff revealed that he/she is not sure about the schedule in changing the resident's continence care product. Furthermore, since the resident is not on a toilet training program, it depends on the individual PSW's preference regarding when to change the resident's continence care product.

Interviews with an identified PSW and another identified registered staff revealed that toileting resident #35 routinely means taking the resident to the toilet in the morning before breakfast and upon the resident's request.

Interview with another identified PSW revealed that toilet resident #35 routinely means taking the resident to the toilet in the morning before breakfast and upon the resident's request. [s. 6. (8)]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.

Record review revealed that resident #36 is identified with responsive behaviours, and the resident's written plan of care outlines identified interventions for the resident's responsive behaviours.

Interviews with an identified PSW and two identified registered staff revealed that resident #36 has responsive behaviours, and that the interventions for his/her

responsive behaviours requires two people to provide care to the resident at all times; one person to hold the resident's hand and talk to the resident, and the other person to provide the care. Both the identified PSW and identified registered staff confirmed that they have been using the above mentioned approach for a long time as it was effective for them. However, this approach is not reflected in the resident's written plan of care. [s. 6. (10) (b)]

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 (1) there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident (2) that the care set out in the plan of care is provided to the resident as specified in the plan (3) that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care (4) to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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:

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. The licensee has failed to protect residents from abuse by anyone.

Interviews with PSWs and registered staff and review of resident #07's health records revealed that resident #07 was identified to have a history of responsive behaviours. Review of the home's investigation notes revealed that the resident was witnessed with identified inappropriate behaviours on several identified occasions, to discharge of the resident on an identified date.

On an identified date, the resident demonstrated inappropriate behaviour with a staff member and was placed on Dementia Observation System (DOS) monitoring. On an identified date, at an identified time, while on DOS monitoring, the resident demonstrated inappropriate behaviour with an identified resident. The resident was immediately placed on heightened monitoring, where the resident was accompanied by a staff member for a period of six days. On an identified date, the executive director (ED) reviewed the video footage of the identified incident that took place on an identified date. The footage revealed resident #07's inappropriate behaviour with the identified resident. Thereafter, the licensee determined that the behaviour was willful; the resident continued receiving heightened monitoring. On the same day, a few hours later, while on DOS and heightened monitoring, the resident demonstrated inappropriate behaviour with two other residents.

Interview with the DOC and the ED revealed that the incidents identified, were abusive in nature and the home did not protect the identified residents from abuse by resident #07. The resident was charged by the police and the police placed restrictions on the resident, that required the home to discharge resident #07 as they could no longer ensure that they could protect residents and adhere to the police restrictions. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs, is fully respected and promoted.

On August 26, 2014, at 4:00 p.m., the inspector observed resident #19 laying in bed naked, while an identified PSW was changing the resident's incontinent product. The resident's room door was open and privacy curtains were not drawn. The resident could be seen in his state of undress by anyone passing by.

Interview with the identified PSW confirmed that he/she forgot to close resident #19's room door and draw the privacy curtain while providing care. [s. 3. (1) 8.]

2. The licensee has failed to ensure every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection

Act, 2004 is kept confidential in accordance with that Act, is fully respected and promoted.

On August 21, 2014, at 12:15 p.m., during medication administration, the inspector observed empty medication pouches with resident's personal health information visible (name, room number, name of medication prescribed) in a small container on top of the medication cart. The medication pouches were visible to anyone passing by.

Interview with the identified registered staff revealed that the empty medication pouches will remain in the container on top of the medication cart until a later time when they will be removed to a dedicated container in the medication room.

A second incident was observed on August 21, 2014, at 12:50 p.m., when the inspector observed empty medication pouches overflowing in a small container located on top of the medication cart.

Interview with an identified registered staff revealed that the empty medication pouches with residents' personal health information visible, will remain in the container on top of the medication cart until a later time when they will be removed to a dedicated container in the medication room. The identified registered staff stated "that's what we all do" and that "I have been doing it that way since I started working at the home."

A third incident was observed on August 21, 2014, at 1:40 p.m., when the inspector observed a registered staff administering medication. The inspector observed a small container on top of medication cart, containing empty medication pouches with residents' personal health information visible to anyone passing by. The DOC passed by and instructed the identified registered staff to place the container with empty medication pouches inside the medication cart.

Interview with the DOC confirmed that the home does not have a policy regarding disposal of empty medication pouches for residents, and that the expectation is that registered staff will use a small container provided for them to store the medication pouches; then empty the container as needed throughout the shift in an identified container stored in the medication rooms. The DOC indicated that the container with the empty resident medication pouches should be kept in the drawer of the medication cart during the medication administration in order to protect resident personal health information. [s. 3. (1) 11. iv.]

WN #4: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled Snacks is complied with as required in the regulations.

On August 18, 2014, at approximately 2:15 p.m., in the hallway of an identified wing, the inspector observed an identified PSW serving the mid-afternoon snack. An identified recreation assistant (RA), asked the PSW for a snack for a resident as the resident was in the activity room attending an activity program. The identified PSW told the RA to take the cookies from the tray to the resident, and both identified staff did not refer to the diet list prior to giving a snack.

Interview with the RA revealed that he/she did not have to refer to the diet list because he/she asked the PSW, who gave direction. Interview with the PSW revealed that he/she knows the resident; therefore does not need to refer to the diet sheet. If there are any changes to the residents' diet, they will be informed. Furthermore, the identified PSW served the resident a morning snack, and remembered what was given for the snack.

Review of the home's policy titled Snack, revised February 2013, indicates that the PSW must ensure that the menu and diet lists are followed at all times during the delivery of the snack.

Interview with the food service manager (FSM) confirmed that the PSW must refer to the menu and diet list prior to serving snack to every individual residents, even if the PSW served the same resident the morning snack. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and furnishings are maintained in a good state of repair.

On August 19, 2014, inspector #596 observed areas of discoloration and small holes on the tiles on the floor, in the spa room of an identified unit.

Interview with the environmental services manager (ESM) confirmed that the discoloration and the holes were caused by removing the partial wall, and the repair to the floor tiles was not completed after the removal of the wall.

On August 19, 2014, inspector #502 observed hot water dripping from the faucet of the tub in the spa room of an identified unit.

On August 22, 2014, inspector #507 observed hot water dripping from the faucet of the tub in the spa room of an identified unit, as well as discoloration on the tub below the faucet. The ESM attempted to stop the dripping by tightening the control knob and then indicated that the faucet needs to be fixed.

On August 25, 2014, the inspector observed action was taken to repair the floor tiles. [s. 15. (2) (c)]

2. On August 19, 2014, inspector #596 observed loose grab bars located above the toilet next to the spa room of an identified unit.

On August 22, 2014, inspector #507 observed the above mentioned grab bars to remain loose. Interview with the ESM confirmed that the grab bars were loose and repair is required. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A review of bed entrapment audit completed by the ESM on July 22, 2013, showed one zone of entrapment for resident #16's bed system.

Interview with the ESM confirmed that a zone of entrapment was identified for resident #16 in the completed audit. The ESM indicated that the resident's bed is an older style wire frame bed so the mattress keepers will hold the mattress in place. The ESM indicated the only option to solve the entrapment zone is to replace the resident's bed system.

Interview with the ED revealed that corrective action for all bed systems that failed the bed entrapment audit completed in July 2013, is to replace them with new bed systems, and that 17 beds will be replaced by November 2014. The ED confirmed the home's plan to switch resident #16's bed system with a bed system as soon as possible.

On the same day, resident #16's bed system was replaced. [s. 15. (1) (b)]

WN #7: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred, immediately reports the suspicion and the information upon which it is based to the Director.

On two identified dates, three incidents of identified inappropriate responsive behaviour by resident #07 were witnessed by identified PSWs. Record review and interview with the identified PSWs, registered staff and the ADOC revealed that the identified PSWs informed the registered staff as well as the ADOC of the incidents. The registered staff documented the incidents in resident #07's progress notes. Interview with the DOC confirmed that the incident was not reported to the Director as required by the LTCHA 2007. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the responsive behaviours program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #07 was placed on DOS monitoring related to inappropriate responsive behaviour on several occasions. The resident was on DOS monitoring on multiple identified dates.

A review was carried out of the DOS tools for the related monitoring session.

Interview with the PSWs and DOC revealed that the documentation was not completed as required by the intervention. The home acknowledged that the tools did not capture the inappropriate responsive behaviour incidents, which would assist staff to determine trends or patterns in a resident's behaviour. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan is implemented.

Record review revealed that resident #35 is incontinent of bladder and bowel, and he/she wears continence care products. The written plan of care for the resident indicates that staff are to toilet the resident routinely to reduce episodes of incontinence and to ensure dryness and comfort.

Interview with an identified PSW confirmed that the resident is asked whether he/she would like to go to the toilet at identified times. The resident is assisted to the toilet if the response is yes. Interview with an identified registered staff revealed that the resident is assisted to the toilet every morning and as per resident's request.

Interview with the DOC revealed that the routine practices for residents who are incontinent, not on the toileting program, and not able to request help are to have their continence care products checked every two hours and changed if they are wet. Staff are required to ask those residents who are able to request help every two hours whether their continence care product need to be checked and changed if they are wet. Furthermore, the DOC confirmed that resident #35's plan of care related to the toileting program was not individualized and that the meaning of routine is left to interpretation. [s. 51. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions are taken to meet the needs of the resident with responsive behaviours including interventions, and that the resident's responses to the interventions are documented.

Record review of resident #36's progress notes revealed that the resident exhibited numerous responsive behaviours, between identified dates. Of the reviewed episodes, three of them, only "resident's identified behaviours noted by PSW" were documented in the resident's progress note.

Interviews with an identified registered staff and the DOC confirmed that resident #36's responsive behaviours including actions taken to respond to the needs of the resident and the resident's responses to interventions were not documented in the above mentioned incidents. [s. 53. (4) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who receive training in relation to the homes' policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities' receives retraining annually as required by the regulations.

Review of the home's policy titled Abuse and Neglect Resident, revised April 2013, indicates that "annual mandatory education will be provided to all Leisureworld staff and that the training will include criteria as outlined in the LTCH Act."

Record review of the home's mandatory education package and interview with the DOC revealed that eight per cent (8%) of all staff did not receive training in Abuse: zero tolerance / mandatory reporting in 2013. [s. 76. (4)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On August 18, 2014, the inspector observed a folder with the identified inspection reports placed in a file holder at the home's entrance. However, there was no label on the file indicating the inspection reports are there. In addition, the identified inspection reports were not included in the file.

The absence of the above mentioned reports was confirmed in an interview with the executive director (ED). [s. 79. (3) (k)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff release the resident from the physical device and reposition at least once every two hours.

The inspector reviewed resident #16's health record with the DOC related to hourly safety checks and repositioning documentation. Record review revealed that documentation about hourly checks and repositioning of the resident were incomplete. Resident #16's care plan outlined interventions for restraint usage including hourly safety checks and repositioning every two hours.

Interview with identified PSW on day shift revealed that resident #16's identified restraint is applied at an identified time and the resident stays in the wheelchair all day, and requires repositioning every 2 hours. The identified PSW confirmed that on an identified date, the resident was transferred into the wheelchair and the identified restraint was applied at at an identified time. The PSW confirmed that the resident was repositioned only once between an identified period of time, and not in accordance with the directions in the kardex. The PSW stated that she was "busy" with other tasks and involved in providing care to another resident. [s. 110. (2) 4.]

2. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Review of registered staff restraint evaluation documentation by shift and interview with the DOC confirmed that the registered staff did not complete the restraint evaluation on an identified dates, during identified shifts for resident #16. [s. 110. (2) 6.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis.

Record review and interviews with the executive director and the DOC revealed that an analysis of the restraining of residents was not completed on a monthly basis in 2013. The DOC confirmed that regular monthly analysis and review of residents using restraints commenced in April, 2014. [s. 113. (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided training in falls prevention and management.

Record review and interview with the DOC confirmed that 14% of all direct care staff did not receive training on falls prevention and management in 2013. [s. 221. (1) 1.]

2. The licensee has failed to ensure that all direct care staff are provided training in skin and wound care.

Record review and interview with the DOC revealed that 14 per cent of direct care staff did not receive training on skin and wound care in 2013. [s. 221. (1) 2.]

3. The licensee has failed to ensure that training related to continence care and bowel management is provided to all staff who provide direct care to residents on an annual basis.

Record review and interview with the DOC confirmed that 14 per cent of direct care staff did not receive training related to continence care and bowel management in 2013. [s. 221. (1) 3.]

4. The licensee has failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

Record review and interview with the DOC confirmed that 8 per cent of nursing staff (registered staff and PSWs) did not receive training on restraints in 2013. [s. 221. (1) 5.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered immunizations against pneumoccocus in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review and interview with the ADOC revealed that resident #37 was admitted to the home on an identified date, and was not offered the required immunization. [s. 229. (10) 3.]

Issued on this 29th day of September, 2014

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

Irina Kalma

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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 15, 2014	2014_321501_0014	T-000133-14	Resident Quality Inspection

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 - ALTAMONT
92 ISLAND ROAD SCARBOROUGH ON M1C 2P5

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, September 2, 3, 4, 2014.

This report contains findings from inspector #501, Susan Semeredy, which were inadvertently omitted in the initial RQI report #2014_370162_0007.

During the course of the inspection, the inspector(s) spoke with the executive director, director of care, associate directors of care, director of resident programs, food services manager, environmental services manager, MDS RAI coordinator, registered staff, registered dietitian, recreation assistant, housekeeping staff, personal support workers, dietary aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to 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 the resident's care needs change.

On August 18, 2014, the inspector observed resident #1 being provided total assistance with his/her lunch meal. Record review revealed that resident #1 requires limited assistance with eating. Staff interviews confirmed that resident #1 requires extensive to total assistance with eating. Interview with the food services manager confirmed that this plan of care needs to be updated because the resident's needs have changed. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time 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. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On August 20, 2014, the inspector observed on unit three a bathroom door open with a spray bottle that contained virudex-7 hanging from a railing. Interview with an identified housekeeper revealed she had asked nursing staff to leave this door open because she was going to clean it and had left it unattended to finish cleaning in another room. Interview with one of the ADOCs confirmed that this door should be locked at all times and that virudex-7 is a hazardous chemical that should be kept inaccessible to residents. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

The home's policy #V9-310 titled Meal Services Objectives, revised February 2013, states that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide assistance required by the resident.

On August 18, 2014, the inspector observed that resident #1 was served a lunch meal and no one was available to provide assistance for at least five minutes. Staff interviews revealed that resident #1 requires extensive to total assistance with eating. Interview with the food services manager confirmed that resident #1 should not have been left a meal until someone was available to provide assistance. [s. 73. (2) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Resident interview and record review of the Residents' Council meeting minutes revealed that the home does not share the results of the satisfaction with the Council. Interview with the director of resident programs confirmed that the home has not made available the result of the most recent satisfaction survey. [s. 85. (4) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On August 18, 2014, the inspector observed a pair of used nail clippers in the bathroom of unit three. Interview with a PSW revealed that this item should not be left there as there was no way to identify which resident it belonged to. Interview with an identified registered staff member confirmed that staff should not use unlabelled nail clippers as this could spread infection. [s. 229. (4)]

Ontario

Ministry of Health and Long-Term Care

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Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 15th day of December, 2014

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

S. Kennedy

Original report signed by the inspector.