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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2015	2015_265526_0010	H-002395-15	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 - STREETSVILLE
1742 BRISTOL ROAD WEST MISSISSAUGA ON L5M 1X9

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

THERESA MCMILLAN (526), LAURA BROWN-HUESKEN (503), MELODY GRAY (123)

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): May 7, 8, 12, 13, 14, 19, 20, 21, and 22, 2015.

The following Critical Incident inspections were conducted simultaneously during this RQI: H-000858-14, H-001219-14, H-001316-14, H-002149-15, and H-002237-15.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Director of Dietary Services (DDS), Resident Assessment Inventory (RAI) Coordinator, Director of Resident Programs and Admissions, Resident Relations Coordinator, Education Coordinator, Environmental Services Manager, Registered Dietitian (RD) , Dietary Aides (DA), Housekeepers, Maintenance staff, Registered Nuses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Pharmacist, Physiotherapist, Physiotherapy assistants, family members, and residents.

During the course of this inspection, the Long Term Care Homes (LTC) Inspectors toured the home; observed meal and snack service, residents and staff; reviewed resident health records, policies and procedures, dietary documents, training and programme evaluation documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **4 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 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 failed to ensure that the home's policy titled "Snacks, #V9-445", last revised February, 2013, was complied with.

The policy indicated that the Personal Support Worker (PSW) responsible for the delivery of snacks was responsible for ensuring that accurate documentation was completed for the amount of food and fluid the resident had consumed for each snack pass. During interviews with residents #106 and #103, they indicated that they were not regularly offered snacks during the afternoon (PM) and before bed (HS) snack pass.

Resident #106’s food intake records for April 23 to May 22, 2015 were reviewed. The resident's PM snack intake was recorded as "Not Applicable" on seven out of 30 days by the PSWs.

Resident #103’s food intake records for April 23 to May 22, 2015 were reviewed. The resident's PM snack intake was recorded as "Not Applicable" on 21 out of 30 days by the PSWs. The residents’ supplemental meal and snack records (titled "Meals and Snacks PRN") where blank for the review period.

During interview, PSWs confirmed that a record of "Not Applicable" was documented by them if they did not see a snack available for the resident, which is to be provided by the previous shift. The residents’ clinical records revealed that the residents did not have dietary snack restrictions and should have been offered the PM snack daily.

Interview with the Director of Care (DOC) confirmed the process for charting snack intake for morning PSWs, who administered the snack, was to document under as needed (PRN) Meals and Snacks in Point of Care (POC). The PM snack intake record for both residents was incomplete and snack intake could not be verified by staff. [s. 8. (1) (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, 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During the lunch meal observation on May 7, 2015 residents #303 and #304 were observed by the Long Term Care inspector to be served their desserts while they were consuming their main course. Neither resident was observed to request that the two courses be served together. An interview with the home's Director of Dietary Services revealed that the residents were not assessed to require multiple courses to be served at one time and that residents should be served course by course. [s. 73. (1) 8.]

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 home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #3: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council and Family Council was sought in developing and carrying out the satisfaction survey, and in acting on its results as evidenced by:

The 2014 and 2015 Family Council and Residents' Council meeting minutes were reviewed and did not contain a record of the licensee seeking the advice of the Councils in developing and carrying out the satisfaction survey. The Resident Relations Coordinator (RRC) was interviewed and confirmed that the home did not seek the advice of the Family Council or the Residents' Council in developing and carrying out of the satisfaction survey. Also, the RCC indicated that the home was unable to make changes to the questions on the satisfaction survey and was unable to make changes to the way the satisfaction survey was carried out.

The home did not seek the advice of the Family Council or Residents' Council in developing and carrying out the 2014 satisfaction survey. [s. 85. (3)]

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 seeks the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #4: 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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

On May 22, 2015, the Long Term Care Homes (LTC) Inspector observed an unlabeled bedpan positioned on the floor between the toilet and the wall of a bathroom shared by four residents; the bathroom was situated between two rooms, each with two residents. During interview, PSW staff stated that the bedpan was used during the night by resident #406.

Review of resident #406's health records and the home's infection control records indicated that the resident had an infectious disease requiring the implementation of contact precautions. During interview, PSW staff confirmed that the bedpan should not have been stored behind the toilet in the bathroom.

The home's "Additional Precautions in Infection Control" policy number V6-005, Volume 6 Infection Control, last revised on August 2013, directed staff to do the following if contact precautions were in place: "In addition to routine precautions, contact precautions include the following:....Equipment and supplies should be dedicated to the resident identified and stored in a way that prevents use for or by other residents."

During tour of the home with the LTC Inspector on May 22, 2015, the DOC stated that resident #406's bedpan should have been disinfected and stored in the designated area in the home and not stored in an area accessible to other residents such as in the residents' bathroom. The DOC confirmed that staff had not implemented the home's Infection Control policy. [s. 229. (4)]

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 staff participate in the implementation of the program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On May 8 and 19, 2015, Long Term Care Homes (LTC) Inspectors observed resident #112 with an alteration of skin integrity with an interruption to the dermal layer. Review of skin assessments conducted in November, 2014, and February, 2015, indicated that the resident had skin lesions that were being monitored by the physician. The most recent progress note regarding the resident's skin integrity was entered in September, 2014, and indicated that the resident had received treatment for skin lesions; no physician notes regarding the skin lesions were found after September, 2014. During interview, PSW staff stated that the lesions would open periodically, heal and then reopen. During interview, two registered practical nurses (RPNs) stated that resident #112 had not been assessed for the skin lesions using an instrument that was specifically designed for skin and wound, was not being assessed weekly, and was not receiving treatment to the area of altered skin integrity. The management of resident #112's altered skin integrity was not included in their plan of care.

The home's "Skin Care Program" policy V3-1400 in Resident Care Manual Volume 3,

last revised February 2012, directed staff to conduct a head to toe skin assessment when altered skin integrity was observed and weekly skin assessments using the Skin Ulcer Treatment and Assessment record for all residents with altered skin integrity.

During interview, the Associate Director of Care (ADOC) confirmed that resident #112's altered skin integrity had not been assessed using an instrument specifically designed for skin and wound assessment and that this should have been done initially and on a weekly basis until the wound was healed. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

On May 8 and 19, 2015, Long Term Care Homes (LTC) Inspectors observed resident #112 with an alteration of skin integrity. Review of the resident's health record indicated that resident #112 had received treatment in September 2014, for skin lesions, and was noted to have skin lesions in November 2014, and February, 2015. The only dietary progress note since September, 2014, was completed in February, 2015, did not make reference to the resident's altered skin integrity and indicated that the resident was a moderate nutritional risk.

The home's "Skin Care Program" policy V3-1400 in Resident Care Manual Volume 3, last revised February 2012, directed staff to complete a referral to the Registered Dietitian for any resident with altered skin integrity. During interview, the ADOC confirmed that resident #112 had not been referred for assessment by the Registered Dietitian for alteration to skin integrity according to the home's policy. [s. 50. (2) (b) (iii)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations as evidenced by:

The 2014 and 2015 Family Council Minutes were reviewed and included the concerns and recommendations of the Family Council. There were no written responses from the licensee to the advice related to concerns or recommendations noted in the Family Council Minutes.

The home was requested to produce records of the licensee's written responses to the Family Council's concerns and recommendations. The written responses of the licensee were not produced as requested. The Resident Relations Coordinator(RRC) was interviewed and confirmed that the home did not respond in writing to the Family Council advice concerns or recommendations and that the structure of the Family Council had recently changed.

The home did not respond in writing within 10 days of receiving the Family Council concerns or recommendations. [s. 60. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including the following:

i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces as evidenced by:

The home's "Housekeeping Policy and Procedures Housekeeping Aide", last revised May 2015 and Definitions of Cleaning were reviewed and included: "Daily Spot Cleaning-obvious soilage: remove garbage, spot mop, dust mop, check the walls for spills as well as the floor. Check the privacy curtain for stains. Report and deficiencies in Maintenance book."

On May 20, 2015, resident #104 reported to the LTC inspector that the housekeeping department staff did not clean the floor under their bed. The inspector wrote the inspector's name and the date placed the crumpled piece of paper under the resident's bed. On May 21, 2015 at 1600 hours the inspector returned and retrieved the crumpled paper from the floor under the resident's bed. A thin layer of dust was observed on the floor under the resident's bed.

The Environmental Services Manager (ESM) was interviewed on May 21, 2015, and confirmed that it was the home's expectation that the housekeeping department staff clean the floors in the residents' rooms daily. Also, that resident #104's bedroom floor including the area under the bed was scheduled for spot cleaning which included dust mopping and spot mopping.

The home did not ensure that procedures were implemented for the cleaning of the floor under the bed of resident #104. [s. 87. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's drug destruction and disposal policy, that any controlled substance that was to be destroyed and disposed of, was stored in a double-locked storage area within the home, separate from any controlled substance that were available for administration to a resident, until the destruction and disposal occurred was implemented.

The home's policy for "Medication Management-Controlled and Narcotic Medications", Resident Care Manual Volume 3, last revised April 2013, directed staff to ensure that "All controlled and narcotic substances shall be stored under double lock at all times accessible only by a registered nursing staff" and "the count sheet is wrapped around the narcotics and placed into narcotic discard drop bin".

On May 13, 2014, the Pharmacist and DOC showed the LTC Inspector that controlled and narcotic substances to be discarded were stored in a locked cabinet, within an unlocked closet within an unlocked room. During observation on May 7, 8, 12, and 13, 2014, the door to the room was left open throughout the day. There was no locking mechanism on the closet door. During interview on May 14, 2015, the DOC confirmed that the narcotic and controlled substances to be discarded were not stored under double lock at all times according to the home's policy. [s. 136. (2) 1.]

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

Issued on this 12th day of June, 2015

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

Original report signed by the inspector.