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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 4, 2013	2013_191107_0018	H-000493-13	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 - STREETSVILLE
1742 BRISTOL ROAD WEST, MISSISSAUGA, ON, L5M-1X9

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 17, 21, 24, 2013

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Associate Director of Care, Food Services Manager, Registered Dietitian, Registered Nursing staff, Personal Support Workers (PSW), and front line dietary staff

During the course of the inspection, the inspector(s) Toured the home, observed care, reviewed the clinical health record for an identified resident, observed the noon meal service

The following Inspection Protocols were used during this inspection:
Dining Observation

Nutrition and Hydration

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(b)]
Staff did not collaborate with each other in the implementation of the plan of care for resident #001 at an observed medication pass. The resident had a plan of care that required a nutritional supplement to be administered with the medication pass. Not all staff providing the supplement collaborated with each other in the method of administration of the supplement and it was provided in a manner that was not consistent with the resident's needs and their plan of care. [s. 6. (4) (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 with ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(4)]
The registered dietitian did not assess resident #001's hydration status and any risks related to hydration after interventions for hydration were initiated by the Nurse Practitioner. The registered dietitian identified the Nurse Practitioner's interventions in the "Resident Assessment Protocol" (RAP) of the same date, however, there was no nutritional assessment of the resident's hydration in relation to their assessed hydration needs with no change to the plan of care in relation to hydration. The Dehydration RAP, completed the same day stated that it was combined with the Nutritional Status RAP which did not include an assessment of the resident's hydration status in relation to the Nurse Practitioner's interventions. [s. 26. (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 with ensuring that the registered dietitian assesses residents' hydration status and any risks related to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69]
Resident #001 had gradual weight loss over a six month period then documented significant weight loss in the seventh and eighth month. Outcomes were not evaluated in relation to the established goal for weight maintenance. The resident had a goal identified on their plan of care for weight maintenance, however, interventions were not revised despite ongoing weight loss. Nutritional interventions were not revised, however, the resident's goal weight was reduced in the eighth month as the resident had fallen below their previous goal weight range. [s. 69.]

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 with ensuring that residents with significant weight changes, and weight changes that compromise the resident's health status, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: 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).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(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. [O.Reg. 79/10, s. 73(1)8]
Meals were not served course by course for resident #002. Staff had just started assisting the resident with their soup when their hot entree was placed on the table. The entree sat on the table getting cold while the resident was assisted with their soup. The Administrator confirmed that meals were to be served course by course and the soup should have been finished/cleared prior to the entree being placed on the table. [s. 73. (1) 8.]

2. [O.Reg. 79/10, s. 73(1)10]
Proper techniques were not used to assist residents with eating, including safe positioning of residents, at an observed lunch meal.
A) Resident #003 was not positioned safely while being assisted with eating. The resident's head was tilted slightly back with their chin un-tucked (chin towards the ceiling) and the resident had slid down in their wheelchair during the meal. The resident was coughing while being fed their meal.
B) Numerous residents had their mouths scraped with metal spoons while being fed by staff. Staff had facecloths available at the tables for wiping residents' mouths, however, were using their spoons for scraping the food off residents' mouths. The Administrator confirmed that staff were to use the facecloths when feeding residents. [s. 73. (1) 10.]

3. [O.Reg. 79/10, 73(2)(a)(b)]
At an observed lunch meal, a meal was placed on the table for resident #002 prior to staff being available to provide assistance with eating. The resident's soup and hot beverage were placed on the table while the staff member assisted the other two residents at the table. All three residents at that table required assistance with eating at that meal. The resident's soup was left uncovered and had cooled enough that there was a thick coating on the top and staff then proceeded to feed the resident the cold soup. The resident was not able to voice their preferences. [s. 73. (2)]

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 with s. 73(1)8, 73(1)10, 73(2)(a) and 73(2)(b), to be implemented voluntarily.

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. [O.Reg. 79/10, s. 229(4)
Not all staff participated in the implementation of the infection prevention and control program. The resident had a transmissible infection.
A) Resident #001 had contact precautions initiated for an infection with posting outside the resident's room. On a specified date and time, a PSW was delivering the snack cart and entered resident #001's room, provided care, then went and got clean beverage glasses off the snack cart, poured juice and gave the fluids to the roommate without washing their hands. The PSW also entered another room with contact precaution signage and did not wash their hands upon exiting the room.
B) On a specified date and time a PSW provided personal care to resident #001 and exited the room wearing gloves. The inspector inquired about what type of contact precautions the resident required and the PSW stated gloves only. The home's policy related to the specific infection required staff to wear both gloves and a long sleeved gown when providing care to residents with the specific infection.
C)At the observed noon meal service, a PSW was feeding resident #001 and did not wear protective equipment while assisting the resident. [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 with ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 4th day of November, 2013

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

M Warrener, RD