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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2014	2014_266527_0010	H-000432-14	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 - STREETSVILLE
1742 BRISTOL ROAD WEST, MISSISSAUGA, ON, L5M-1X9

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

KATHLEEN MILLAR (527), VIKTORIA SHIHAB (584), YVONNE WALTON (169)

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): April 29, 30 and May 1, 2, 5, 6, 7, 8 9, 2014

Susan Porteous Inspector #560 also conducted Stage One of the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care, Environmental and Maintenance Manager, Food Service Manager, Registered Dietitian, Director of Resident Programs and Admissions, the Resident Assessment Instrument (RAI) and Rehabilitation Coordinator, Resident Relations Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Housekeeping, Laundry staff, Residents and Families.

During the course of the inspection, the inspector(s) toured the home, observed all care areas, observed meal and snack services, observed laundry services, reviewed clinical records, reviewed policies and procedures, reviewed training records and reviewed minutes of meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Snack Observation
Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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. (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 did not ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

A review of the clinical record for Resident #109 revealed that a Speech Language Pathologist (SLP) assessed the resident's swallowing ability in April 2013 and recommended the resident should get good oral care before and after meals. The resident's plan of care conflicted with the SLP recommendations, indicating the resident was to receive oral care at AM and PM. The Personal Support Workers (PSWs) did not have clear oral care directions. Interview with the PSW confirmed the staff provided oral care in the morning before breakfast, after AM snack and after lunch. Interview with the Associate Director of Care confirmed the resident's plan of care should have been updated with the SLP recommendations to provide clear oral care direction to staff.

A review of the plan of care for Resident #106 revealed the resident was to receive labelled apple sauce at AM snack and labelled pineapple juice at all snack times. Interview with the Registered Dietitian (RD) and the Food Service Manager (FSM) confirmed the labelled snacks were to be provided to the resident in place of regular snack options. A review of all labelled snacks in the home confirmed there was no clarification of whether labelled snacks were provided in combination with, or instead of, the regular snack option. PSWs confirmed the directions regarding provision of

labelled snacks for the resident were unclear. The RD and FSM confirmed the snack labels should be more clear to provide clear direction to staff.

A review of the plan of care for Resident #109 revealed there were no clear directions to staff to achieve the resident's weight management goals. The resident had a current Body Mass Index (BMI) below the recommended range, and with a progressive weight loss. There were two related goals identified in the current plan of care: to prevent further weight loss and to maintain Goal Weight Range (GWR) over the next three months. Both goals did not have related interventions to direct care staff. An interview with the Registered Dietitian (RD) revealed the intervention was to maximize food intake, however, this was not clearly communicated to direct care staff. [s. 6. (1) (c)]

2. The plan of care for Resident #52 identified the resident wore yellow briefs on the day shift and purple briefs on the evening and night shift, however in another area of the plan of care it was not specific as to what the resident wore for incontinence or whether the resident required toileting. PSWs confirmed the directions were not clear. [s. 6. (1) (c)]

3. The licensee did not ensure Resident #107 was reassessed and the plan of care revised at any time when the resident's care needs change.

Clinical records for Resident #107 revealed the resident's nutritional goals included maintenance of weight within a certain range. The resident's most recent weight and Body Mass Index (BMI) indicated a severely underweight status. Weight records confirmed the resident had been above the calculated Goal Weight Range (GWR) since October 2013. The resident was not reassessed to determine an appropriate GWR since October 2013, with the plan of care containing an outdated GWR. The Registered Dietitian (RD) confirmed the GWR should be reassessed and the plan of care updated to reflect the change in the resident's health status. [s. 6. (10) (b)]

4. The licensee did not ensure the plan of care was reviewed and revised at least every six months and at any time when Resident #109's care needs changed.

A review of the clinical record for Resident #109 revealed that a Speech Language Pathologist (SLP) assessed the resident's swallowing ability in April 2013 and recommended the resident should receive good oral care before and after meals. The resident's plan of care stated the resident was to receive oral care at AM and PM. The

plan of care was not updated to reflect SLP recommendations for longer than one year. The Associate Director of Care confirmed the plan of care should have been updated upon receipt of SLP recommendations. [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 the plan of care provides clear directions to staff and others who provide direct care to each resident, and the residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' 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:

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 did not ensure the policy named "Snacks, # V9-445", revised February 2013, was complied with.

The policy indicates the Personal Support Worker (PSW) responsible for the delivery of snacks is responsible for ensuring that accurate documentation is completed for the amount of food and fluid the resident had consumed for each snack pass.

An interview with Resident #102 revealed the resident was often not offered snacks during the afternoon snack pass. The resident's food intake records for the last two months were reviewed. The resident's PM snack intake was recorded as "Not Applicable" on eight out of thirteen days by the PSWs.
PSWs confirmed that a record of "Not Applicable" is documented by them if they do not see a snack available for the resident and they assume that either the previous shift PSWs or recreational staff had provided the PM snack and documented accordingly.
The resident's supplemental meal and snack records (titled "Meals and Snacks PRN") where blank for the review period. Thus, there was no record of the resident's PM snack intake for eight days.
The resident's clinical records and interviews with the Food Service Manager (FSM) and the Registered Dietitian (RD) confirmed the resident should have been offered a PM snack daily.

Resident #101 revealed during an interview that PM snacks are not always provided. The resident's food intake for the last two months was reviewed. On eleven out of the thirteen days the resident's PM snack intake was recorded as "Not Applicable". The PRN Meals and Snacks intake record was blank. Staff did not document the resident's PM snack intake 85% of the time.

Interviews with the Director of Care and the Associate Director of Care confirmed the process for charting snack intake was for morning PSWs and recreational staff to document under PRN Meals and Snacks in Point of Care. 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 staff compliance with the home's policy - Snacks #V9-445, February 2013, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff used all equipment supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The home had three oropharyngeal suction machines located in three areas of the home: one in the dining room on the lower level, one at the nurses station on the lower level, and one on the main floor. Four residents were observed and their clinical records reviewed, which identified each resident was at high risk for choking and/or aspirating. There were no operating instructions accessible for any of the suction machines. Hair, debris and/or lint were noted on the machines. The operating instructions identified that: the machine came equipped with a felt silencer that should be changed every 3-6 months as required; the machine should be inspected before use; the air opening should be kept clean of lint, hair and debris; and the machine should be run for a few minutes before use to ensure it was operating properly. The Registered staff, the Associate Director of Care and the Director of Care confirmed there were no checks conducted on the machine to ensure it was operating properly, the operating instructions were not accessible on the equipment and there had been no recent training on how to operate the equipment. [s. 23.]

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 staff are in compliance with the manufacturers operating instructions for suctioning equipment, to be implemented voluntarily.

WN #4: 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. The licensee did not ensure that Resident #107 was assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated when the resident experienced a weight change that compromised the resident's health status.

Clinical records for Resident #107 were reviewed and revealed the resident's weight and Body Mass Index (BMI) had decreased, classifying the resident as severely underweight and further compromising the resident's health status.

A review of the Registered Dietitian's (RD's) clinical notes confirmed the resident was to undergo a monthly weight review. The RD confirmed the monthly weight review consisted of a meeting between dietary and nursing staff to discuss weight changes and interventions and the meeting had not occurred. The monthly weight change review was not completed for Resident #107 as planned. Weight maintenance interventions were not reviewed or revised until two months after the change in weight. [s. 69. 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 each resident is assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated if a resident experiences weight changes, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

The home's three electrical oropharyngeal suction machines were not checked to ensure they were in good working order for resident use in an emergency situation. In addition, there were expired gloves and expired suction tubing found in the suction machine storage drawers. The Director of Care confirmed there were no checks conducted on the suction machines to ensure they were in good repair. [s. 90. (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 be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:

1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.

2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee did not ensure that training in additional areas, specifically, safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that was relevant to the staff member's responsibilities, was provided.

The home had three electrical oropharyngeal suction machines located in various areas of the home, for resident choking and aspiration emergency situations. There was one suction machine in the only dining room on the lower level, there was another machine in the cupboard at the nurses station on the lower level and there was a suction machine on the main floor. In addition, a number of residents were identified on the plan of care as high risk for aspiration and/or choking. None of the machines had operating instructions available. The Registered staff were unable to demonstrate the skill of properly connecting the tubing to the machines. Staff confirmed they had not received any training on suctioning in approximately two years. The home had no training records of any suctioning training. The Associate Director of Care and Director of Care confirmed there had been no training. [s. 218. 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 to ensure Registered staff have the additional training to safely operate the suction equipment in order to mitigate risk to residents, to be implemented voluntarily.

WN #7: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #052 did not receive an assessment of incontinence at the time of admission or annually using the clinically appropriate assessment instrument utilized by the home. There was no documentation on the clinical record of any assessments related to the causal factors, patterns, type of incontinence and potential to restore function with specific interventions. The Registered Staff and the Director of Care confirmed there was no admission or annual Continence Assessment completed. The lack of assessment for Resident #052 had resulted in a lack of clarity for PSWs in providing care. [s. 51. (2) (a)]

WN #8: 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 did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Interviews with the Residents' Council President and the Council's liaison revealed the Council had not been asked for their input into developing and carrying out the satisfaction survey. A review of Residents' Council's meeting minutes from January 2012 to May 2014 confirmed this. The Administrator was unable to confirm that the Residents' Council's input into developing and carrying out the satisfaction survey was sought. [s. 85. (3)]

Issued on this 21st day of May, 2014

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

Kathleen Millar (#527)