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
Jun 17, 2014	2014_205129_0011	H-000649-14	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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 29, 30 and June 3, 2014

During the course of the inspection, the inspector(s) spoke with residents, regulated and unregulated nursing staff, Behavioural Support Ontario staff, Resident Assessment Instrument-Minimum Data Set coordinator, Assistant Director of Care and the Director of Care in relation to Log # H-000649-14.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical records, reviewed 2013 training records related to Restraints/PASD and Responsive Behaviours as well as reviewed the home's [Restraint and Personal Assistance Services Devices Physical] and [Responsive Behaviours Management] policies

The following Inspection Protocols were used during this inspection: Responsive Behaviours

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 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 did not ensure that when bed rails were used for resident #001, resident #002 and resident #003 that these residents were assessed in accordance with evidence-based practices or prevailing practices in order to minimize the risk to the resident, in relation to the following: [15(1)(a)]
Resident #001 was identified as being a high risk for falling, had a history of falling, had a cognitive impairment, was identified as being restless and agitated and at the time of this inspection the resident was confined to bed. Clinical records and staff confirmed that the use of bed rails was initiated on an identified date in 2014. The Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed that the decision to implement the use of bed rails was not based on an assessment of the resident's condition, functional needs or risk of injury associated with behaviours the resident was demonstrating.
Resident #002 was identified as requiring the assistance of one staff for safe transfers, was non-compliant with requesting assistance and would self- transfer, had a cognitive impairment and was identified as a high risk for falling with a history of falling. Staff confirmed that bed rails were being used for this resident and clinical documentation indicated that the use of bed rails were initiated on an identified date in 2013. The DOC and the ADOC confirmed that the decision to implement the use of bed rails was not based on an assessment of the resident's condition, functional needs or risk of injury associated with the risk of self-transferring.
Resident #003 was identified as being a high risk for falling and had a cognitive impairment. Staff confirmed that bed rails were being used for this resident and clinical documentation indicated the use of bed rails were initiated on and identified date in 2014. The DOC and the ADOC confirmed that the decision to implement the use of bed rails for this resident was not based on an assessment of the resident's condition or functional status.
The DOC and ADOC confirmed that the home has not developed or implemented an individualized resident assessment in accordance with evidence-based practices or prevailing practices when the use bed rails are being considered for resident care. [s. 15. (1) (a)]

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 and ensuring that when bed rails are used the resident is assessed in accordance with evidenced based practices and, if there are none, in accordance with prevailing practises, to minimize risk to the resident, to be implemented voluntarily.

WN #2: 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 did not ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, in relation to the following: [53(4)a]
-There was no evidence documented in resident #002's clinical record that attempts were made to identify triggers for behaviours being demonstrated by this resident. Staff identified both in the care plan and on Resident Assessment Instrument-Minimum Data Set (RAI-MDS) reviews completed on February 12, 2014 and March 14, 2014 that the resident demonstrated four identified responsive behaviours. Behavioural Support Ontario (BSO) staff confirmed that although the team talked about the behaviours this resident was demonstrating they did not documented attempts to identified triggers.
-There was no evidence documented in resident #003's clinical record that attempts were made to identify triggers for behaviours being demonstrated by this resident. Staff identified in the care plan, on a RAI-MDS review completed on March 3, 2014 and on care flow sheets that the resident demonstrated four identified responsive behaviours. Behavioural Support Ontario staff confirmed that they did not documented attempts to identified triggers for these behaviours.
-There was no evidence documented in resident #001's clinical record that attempts were made to identify the triggers for the behaviours being demonstrated by this resident. Staff identified in both the care plan and on care flow sheets that the resident demonstrated four identified responsive behaviours. Staff assessed the resident as being at risk for injury to themselves as a result of these behaviours and indicated the resident required constant supervision and observation. Behavioural Support Ontario staff confirmed that they did not documented attempts to identified triggers for these behaviours. [s. 53. (4) (a)]

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 and ensuring that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, to be implemented voluntarily.

WN #3: 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 that where the Act or this regulation requires the licensee to have, institute or otherwise put in place any policy or procedure that the policy or procedure is complied with, in relation to the following: [8(1)(b)]
a) Staff did not comply with the directions contained in the home's [Restraint and Personal Assistance Services Device Physical] policy identified as # V3-1340 and revised in April 2013 when they did not complete the Restraint PASD Assessment/Alternative Form.
-Staff implemented bed rails as a PASD for resident #001, but did not complete the Restraint PASD Assessment/Alternative Form.
-Staff implemented bed rails as a PASD for resident #002, but did not complete the Restraint PASD Assessment/Alternative Form.
-Staff implemented bed rails as a PASD for resident #003, but did not complete the Restraint PASD Assessment/Alternative Form.

b) Staff did not comply with the directions contained in the home's [Responsive Behaviour Management] policy identified as #V3/092 and dated March 2012 in relation to the following:
- Staff did not comply with the directions to identify behavioural triggers when they did not identify behavioural triggers for residents #001, #002 and #003 when it was documented that these residents demonstrated multiple responsive behaviours.
-Staff did not comply with the directions to refer to High Intensity Needs Program for one to one supervision when they identified that resident #001 required constant monitoring and supervision to prevent the resident from injuring themselves as a result of responsive behaviours this resident demonstrated. [s. 8. (1) (b)]

Issued on this 17th day of June, 2014

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