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
Dec 3, 2014	2014_378116_0015	T-55-14	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 - CHELTENHAM
5935 BATHURST STREET, NORTH YORK, ON, M2R-1Y8

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

SARAN DANIEL-DODD (116), ARIEL JONES (566), VALERIE PIMENTEL (557)

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): October 28, 29, 30, 31 and November 3, 4, 5, 6, 7, 10, 2014.

The following inspections were conducted in conjunction with the Resident Quality Inspection (RQI): T1001-12, T120-13, T431-13, T475-13, T488-13, T494-13,T1043-14.

During the course of the inspection, the inspector(s) spoke with the executive director, director of care (DOC), director of food services, acting environmental service manager, director of resident programs, resident relations coordinator, registered nursing staff, personal support workers (PSW),dietary aides, laundry aide, housekeeping, maintenance technician, family and residents.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident interactions and provision of care, observed meal service, medication administration, reviewed relevant home records, relevant policy and procedures, training records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
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 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 painting schedule policy was complied with.

The home's painting schedule policy (#V8-320, reviewed April 2012) indicated that the environmental service manager (ESM) would develop an annual master painting schedule for the home, focusing on areas of priority, and that painting will be completed according to the master painting schedule by both in-house staff and corporate painters.

Observations of identified resident rooms and resident care areas revealed marred, scuffed, and chipped walls requiring paint and repair. An interview with a maintenance technician revealed that the home does not follow a painting schedule and typically only paints resident rooms when residents are discharged, if there is a lot of wall damage.

The acting ESM confirmed that the home does not have a painting schedule and that the identified areas were in disrepair. [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 the home's painting schedule policy is complied with, to be implemented voluntarily.

WN #2: 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, furnishings and equipment are maintained in a good state of repair.

The following observations were completed during the inspection:
Common Areas:
Identified Tub Room:
- missing stainless steel knob in bottom of ARJO tub
- door protector pushed into wall with surrounding wall damage
- broken wall tile at floor level near west door
- wall damage and chipped paint across an entire wall
- stained upholstery.

Identified Shower Room:
- broken wall tile
- corner door guard lifting around identified shower room doors, corner guard broken off
- damaged doors (splitting wood, exposed underlay)
- exposed patchwork to identified wall
- broken wall tiles in shower stall
- rust spots on hand rail by tub
Identified Shower Room:
- broken wall tiles on right side of door frame

Identified Resident Rooms:
- wall damage above toilet in resident bathroom, chipped paint around door frames in bathroom and west bathroom wall
- chipped paint around door and door frame in the resident bathroom.

A review of the maintenance report logs failed to reveal that the above areas requiring repair had been recorded on the daily maintenance audits or resident room audits. An interview and tour with the acting ESM confirmed the above noted areas required repair and that the home does not have a painting schedule. [s. 15. (2) (c)]

2. On an identified date, the inspector observed the bedside cabinet in an identified resident room to be in disrepair. The laminate cover was peeled off in multiple spots on the top of the bedside cabinet exposing the chipboard underneath.

Interviews with the infection prevention and control nurse and the ED confirmed the resident's bedside table was in disrepair. The home did not ensure the resident's furnishings are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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,furnishings and equipment are kept clean and sanitary and maintained in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required.

Resident interview revealed that an identified resident, has missing teeth and experiences tooth pain. The resident stated that he/she would like to see a dentist and that this service has not been offered.

Staff interview revealed that Toronto Public Health provides annual dental screening, and that residents are referred to Golden Dental Care Services when problems arise or by request.

Record review failed to reveal evidence that the resident had been offered an annual dental assessment and other preventative dental services in 2013. Further record review revealed that the resident had received a dental screening by Toronto Public Health during the spring of 2014, which identified tooth decay, broken teeth, and a need for follow up and further assistance with daily oral hygiene.

Staff interviews revealed that the Toronto Public Health dental screening records were filed away, staff were unaware of the recommendations from the 2014 screening, and there was no follow up provided for preventative dental services to the resident.

An interview with the head nurse confirmed that the identified resident has not seen a dentist since admission, and the resident was not offered annual preventative dental services. The DOC confirmed that there is no standard policy in place regarding dental care. [s. 34. (1) (c)]

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 of the home is offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

WN #4: 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 has failed to ensure that procedures are implemented for cleaning of privacy curtains.

Review of the housekeeping/special projects job routines documents the following responsibilities:
-"when cleaning the rooms the privacy curtains must be pull closed and checked for stains and removed and replaced accordingly with the assistance of special shift".
-"per schedule removal of privacy curtains(1 unit per week, and/or as needed with soiled curtains)".

Review of the cleaning schedule for privacy curtains identified that the privacy curtains for identified resident rooms have not been cleaned for the period of January inclusive to November 2014. Interviews held with an identified housekeeper and the acting ESM confirmed that the home's procedure for cleaning of privacy curtains was not implemented. [s. 87. (2) (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 to ensure that procedures are implemented for cleaning of privacy curtains, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area that is secure and locked.

On an identified date, the inspector observed a prescribed ointment cream left on an identified resident's bedside cabinet unattended.
Interviews with an identified PSW confirmed he/she had placed the prescription ointment on the resident's bedside cabinet and left it unattended. An interview with the registered nursing staff confirmed that the ointment should not be left unsupervised at the resident's bedside.

Interviews with the registered nursing staff and the DOC confirmed the prescription ointments were not stored safely or securely. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A resident is identified with swallowing and chewing difficulties and as per the physician's order requires all medications to be crushed in apple sauce.

On a specified date, during the evening medication pass, the inspector observed a registered staff member administering two oral medications whole.
Interview with the registered staff member stated that the resident receives some medications whole, while others are crushed in apple sauce.
An interview held with the DOC confirmed that all medications are to be administered as specified, and the identified resident should have all medications crushed in apple sauce. [s. 131. (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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the training and orientation program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

- A review of the home's educational records identified that the home currently has a training and orientation program. The DOC confirmed that some of the home's training and orientation program is provided by Preferred Health Care, an affiliated contracted agency. An interview with the DOC confirmed that the home's training and orientation program has not been evaluated and updated in accordance with evidence-based practices, and or in accordance with prevailing practices on an annual basis. [s. 216. (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 that at least annually, the training and orientation program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #8: 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 all staff participate in the implementation of the infection prevention and control program.

On a specified date, the inspector observed a mattress on the bed frame of an identified resident to be in poor condition. The protective cover on the mattress was cracked and a large area was chafed off.

Interviews with the registered nursing staff, infection control nurse and the DOC confirmed that the mattress should be changed as it was a source for infection, the mattress could absorb liquids and other sources of germs. The home's staff did not identify or report the condition of the mattress for follow up under the infection prevention and control program. [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 infection prevention and control program, to be implemented voluntarily.

WN #9: 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents' right to be protected from abuse, is fully respected and promoted.

Record review revealed that an identified resident was roughly handled by a technician from an external company on an identified date.

An identified PSW confirmed witnessing an altercation between the resident and the technician in the doorway of the resident's room, whereby the technician was observed to have placed his/her hands on the resident's shoulders, shaking the resident.

Record review and staff interviews revealed that the resident was blind, had identified behaviours around unknown individuals, and may have been startled by the approach of the ultrasound technician. Further review and interviews confirmed that the resident did not sustain any injuries or ill effects from the incident. The identified technician was told that his/her behaviour was inappropriate and a report was made to the identified company.

An interview with the DOC confirmed that the resident's right to be protected from abuse by anyone in the home was not respected and promoted. [s. 3. (1) 2.]

WN #10: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A review of the annual assessment conducted on a specified date, revealed that an identified resident has impaired visual function. Review of the health record and interviews held with registered staff and PSWs confirmed that the written plan of care does not set out any directions to staff and others who provide direct care to the resident with regards to impaired visual function. [s. 6. (1) (c)]

WN #11: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's vision.

Review of the health record and annual assessment conducted on a specified date, documents an identified resident has visual function impairment related to limited vision and unable to see newspaper headlines but can identify objects due to the aging process. The assessment indicates the visual function is to be addressed in the care plan.

Review of the written plan of care and interviews held with registered staff and PSWs confirmed that the plan of care was not developed to include assessment of the resident's vision. [s. 26. (3) 4.]

WN #12: 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 has failed to ensure that a resident exhibiting altered skin integrity 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.

On a specified date during the inspection, the inspector observed a bruise to the back of an identified resident's hand.

Record review of resident progress notes for a specified period, indicated the resident experienced pain and swelling to the back of the identified hand with slight purple discolouration and bruising. There was no skin and wound assessment tool completed.

Interviews with the registered nursing staff and the DOC confirmed that a skin and wound assessment should have been completed. [s. 50. (2) (b) (i)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review indicated that two identified concerns directed to the administration and nursing departments were raised during the September 2014, Residents' Council meeting. The written response from the head nurse related to the first concern was undated, and the written response related to the second identified concern was provided to the Residents' Council assistant twenty five days later.

An interview with the Residents' Council assistant confirmed that written responses were not provided to these concerns within the designated 10 day time frame. [s. 57. (2)]

WN #14: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.

Staff interviews and a review of the home's current process for determining satisfaction revealed that the home uses the standardized stage one questions from Abaqis plus two additional questions regarding satisfaction with the facility and likelihood of recommendation by residents and family members.

A record review confirmed that the home's current survey is an audit and does not determine satisfaction with all programs and services, such as occupational therapy, physiotherapy, continence care, and skin and wound program. [s. 85. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the home's strategic planning and annual evaluation and an interview with the DOC, confirmed that the annual evaluation of the medication management system was conducted by registered staff and the pharmacist. The medical director and administrator did not participate in the annual evaluation of the medication management system. [s. 116. (1)]

2. The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year and was conducted with an assessment instrument designed specifically for this purpose.

Review of the annual evaluation of the medication management system and an interview held with the DOC confirmed that the home is currently using the Institute for Safe Medication Practice (ISMP) for the purpose of the annual evaluation and not an instrument that is designed specifically for this purpose. [s. 116. (3)]

Issued on this 15th day of December, 2014

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