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
Dec 1, 2015	2015_265526_0023	031024-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON MEADOWS
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), 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): November 12, 13, 16, 17, 18, 19, 20, 23, 24, and 25, 2015

The following Critical Incidents were conducted simultaneously to this RQI:
003064-14 (Transferring, Falls Prevention);
002475-15 (Duty to Protect);
003912-15 (Falls Prevention, Pain Management);
004376-15 (Duty to Protect, Plan of Care);
024082-15 (Transferring);
024743-15 (Falls Prevention);
027108-15 (Transferring, Pain); and
029159-15 (Duty to Protect)

The following complaints were inspected simulaneously during this RQI inspection:
004659-15 (Duty to Protect, Responsive Behaviours, Continence, Resident's Rights);
027117-15 (Attending MD; Resident's Rights, Menu Planning)

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Environmental Service Manager (ESM), the Resident Assessment Inventory (RAI) Coordinator, Registered Dietitian (RD), Physiotherapist (PT), Food Services Supervisor (FSS), Office Manager, dietary staff, Registered Nurse (RN), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), residents and family members.

During the course of this inspection, inspector(s) toured the building (resident rooms, common spaces including dining rooms, tub/shower areas, the kitchen and serveries); reviewed health records, policies and procedures, program evaluations, training records, staff files, menus, food production recipes,and bed entrapment audits; observed care, residents, and staff.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 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 failed to to ensure that there was a written plan of care for resident #047 and #048 that set out (a) the planned care for the resident's.

Resident #047 and #048 both had a history of falls. The plan of care did not include the development of a plan to manage the risk of falling for both residents. The Director of Care and the Resident Assessment Inventory (RAI) Coordinator confirmed there was no plan of care available in the PointClickCare (PCC), the home's electronic documentation system, to manage the risk of falling for both residents. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care was reviewed and revised at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of resident #029's most recent Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment, indicated that the residents continence level. During interview,PSW #106 confirmed this level of continence.

However, the resident's most recent documented care plan, and Resident Assessment Protocol (RAP) indicated a deteriorated continence. Interview with the RAI Coordinator confirmed that the documented care plan and assessment completed during the review were not consistent with the direct care staff observations, and the plan of care had not been updated to reflect the resident's current continence level. (586)

B) According to their health record, resident #061 was taken to hospital on a specified day in 2015 for treatment of an injury to an extremity. Upon returning to the home, the plan of care was changed to reflect their current care needs and activity level. During interview, registered staff #101 stated that the resident's post hospital care was no longer required and their activity level had returned to normal. This was confirmed by LTC inspector observation on November 25, 2015.

Review of the resident's plan of care indicated that it had not been updated to include that post hospital care was no longer necessary. The ADOC confirmed that the plan of care had not been updated since the resident's return from hospital. [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 that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The Director of Care (DOC) identified to the Long Term Care Homes (LTC) Inspector, 11 residents that were assessed as being at a high risk for entrapment. Review of these residents' assessments and plans of care as of November 18, 2015, and interview with the DOC revealed that these residents used bed rails to assist with mobility, positioning, and comfort. The LTC Inspector observed all bed rails for these residents in the up position with no additional devices installed to prevent entrapment. Interview with personal support worker (PSW) #104 confirmed that when in bed, these residents used the bed rails that were in the up position during LTC Inspector observation. They also noted that resident #056 was often found positioned up against their assist rail.

Review of the home's "Facility Entrapment Inspection Sheet" dated May 19, 2015, provided by the home to LTC Inspector on November 17, 2015, indicated that all 11 high risk residents' bed systems failed at least one zone of entrapment. Further review of the audit indicated that 123 of 160 of the beds audited failed at least one zone of entrapment. In addition the audit revealed that there were nine bed systems that had air mattresses where bed rails were raised causing all zones of entrapment to fail in the event of a malfunction of the air mattress. The Environmental Services Manager (ESM) confirmed these conclusions.

During resident observations on November 12, 13 and 16, 2015, LTC Inspectors noted that 28 bed systems of a total of 40 beds had bed rails in the up position. According to the home's bed entrapment audit, 18 of these observed 28 beds had failed at least one zone of entrapment. Five of these failed bed systems with rails raised were occupied, and four failed bed systems with air mattresses and rails in the up position were occupied at the time of this observation.

During interview the DOC and ESM stated that long term plans to address the identified entrapment had been initiated and the home was mitigating entrapment by monitoring residents with bed rails every two hours when in bed. They confirmed the LTC Inspector's observations that the home had not installed temporary devices to address zones of entrapment, particularly for the 11 residents who were identified as being high risk for entrapment. They confirmed that actions to mitigate the immediate risk to residents in 132 beds since they were audited in May 2015 to June 2015 until November 18, 2015, had not taken place to prevent entrapment. [s. 15. (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 bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations

Review of resident #028's progress notes revealed that, on a specified day in 2015, they had reported to registered staff #108 that a staff person injured them. During interview, the resident told the LTC Inspector that a PSW injured them.

During interview, registered staff #108 confirmed that the resident had told them that a staff person had injured them. The registered staff stated that this allegation was not interpreted as abuse but that an Associate Director of Care (ADOC) was notified. The ADOC could not provide investigative notes of this allegation and confirmed during interview that resident #028's alleged abuse by a staff member had not been investigated immediately. [s. 23. (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 to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.

WN #4: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #047, #048, and #061 had a plan of care based on, at a minimum, interdisciplinary assessment of both residents risk of falls.

A) Resident #047 was identified at risk of falling, based on MDS assessment and had a fall on a specified day in 2015 that caused injury. The resident deceased approximately three weeks later. The licensee did not complete an assessment to determine the risk of falling for resident #047 and did not develop a plan of care related to falls prevention. Also, an earlier MDS assessment was completed, however the RAP and plan of care were not developed. This was confirmed by the Director of Care and RAI co-ordinator and lack of documentation. (169)

B) Resident #048 had five falls over a five month period in 2015, and the last one resulted in injuries. The licensee did not complete an assessment to determine the risk of falling for resident #048 and did not develop a plan of care related to falls prevention. This was confirmed by the Director of Care and RAI co-ordinator and lack of documentation. (169)

C) Resident #061 was a medium risk for falls and transferred using a lift and two staff persons. Review of the resident's health records indicated that they had not had a falls risk assessment completed following a return from hospital even though their plan of care was reviewed at that time and their Resident Assessment Protocol (RAPS) indicated that they were a high risk for falls. The ADOC confirmed that the resident's plan of care was not based on an assessment of the resident's risk for falls after their return from hospital. (526) [s. 26. (3) 10.]

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 a plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration programs included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration.

The home's "Monitoring of Resident Weights" policy [number VII-G-20.80 last revised in January 2015] directed staff to do the following:

...3) Request the PSW reweigh the resident if there is an unanticipated weight change (loss or gain) or 2 Kg difference in resident's weight from the previous month.
4) Investigate potential causes of weight variance, including a review of resident's current eating patterns, hospitalizations within the past month, and related symptoms and observations, i.e. weight gain related to fluid retention.
5) Complete monthly weight variance reports and respond to weight variances following the electronic documentation process.
6) Refer to the dietitian if necessary.

During interview, registered staff #101 and #105 confirmed the above home’s policy for weight changes stating the home's expectation that residents with an unplanned weight change of greater than two kilograms should be referred to the dietitian.

Resident #026 was noted to have weight variance greater than two kilograms over a one month period. Review of resident #026’s health record and interview with the Registered Dietitian (RD) indicated that the resident had not been referred to the dietitian. The RD also confirmed that resident had a further negative weight outcome.

During interview, registered staff #105 and the DOC confirmed that the resident #026 did not receive a dietary referral according to the home's nutrition and hydration program policy. [s. 68. (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 the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #6: 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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On November 24, 2015, the LTC inspector observed controlled substances stored in a single locked stationary container in the locked medication room. The Associate Director of Care (ADOC) confirmed that the container was single locked rather than double locked as required by this legislative section. [s. 129. (1) (b)]

Issued on this 7th day of December, 2015

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

Original report signed by the inspector.