Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Oct 15, 2014	2014_266527_0011	H-000436-13, H000892-13	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON WOODS
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

KATHLEEN MILLAR (527)

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 15, 16, 22, 23, 26, 27 and 28, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services staff, Dietary staff, the Maintenance Manager, and the Resident Relations Manager.

During the course of the inspection, the inspector(s) reviewed residents records, the home's investigative notes, logs, policies and procedures, training records, personnel files, staff work schedules, and the home's video surveillance footage.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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. 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

A) Resident #011 went missing from the home in July 2013 through an unlocked stairwell door leading from the secured unit of the home. The resident proceeded down the stairwell and eventually exited the home and was found by a neighbour in a condominium building close to the home. After identification of the resident was verified at the home by the police officer, the police subsequently returned the resident to the home. The home's staff were not aware the resident had been missing for approximately 4 hours, until the Police attended the home.

The PSWs, RNs, RPNs, ADOC, DOC, Administrator and Environmental Services staff confirmed they were expected to ensure doors were locked behind them when using stairwells. The Administrator confirmed that a staff member did not check to ensure the door was locked when they left the unit, and the resident was able to access the stairwell. It was also confirmed that the exit doors were connected to the nurse call response system and when the system alarmed the staff ignored the alarm. The PSWs, RPNs and the Administrator confirmed the alarm was ignored and staff turned off the alarm without checking to ensure all residents were safe and accounted for. The Administrator, RNs and PSWs confirmed they failed to provide a safe environment for resident #011. [s. 3. (1) 5.]

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 every residents rights are fully respected and promoted, 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. 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 (b) is complied with. O. Reg. 79/10, s. 8 (1).

The home's "Skin Care Program" policy, number V3-1400, and revised in February 2012 stated that registered staff were expected to conduct a skin and pain assessment when the missing resident returned to the home after a Code Yellow. Once these assessments were implemented, the resident would subsequently have skin and pain assessments documented in the progress notes each shift for seventy-two hours post incident. Resident #011 was returned to the home by Police in July 2013. The RPN did not conduct a skin and pain assessment in the clinical tools utilized by the home. When reviewing the clinical record for resident #011 there was no documentation on a skin or pain assessment tool. The RN, RPN, Director of Care (DOC) and the Administrator confirmed the first skin and pain assessment when the resident returned to the home should have been performed and documented on the Head to Toe Skin Assessment tool and the Abbey Pain Assessment tool. The RN, RPN, DOC and Administrator confirmed that the RPN did not follow the home's policy. [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 policies, procedures, plans and protocols are complied with, to be implemented voluntarily.

WN #3: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

A) The plan of care for resident #011 stated the resident had occasional insomnia, was to be monitored frequently at nights as resident tries to climb out of bed and was to sleep on a mattress on the floor in the television lounge at night. Also, documented in the plan of care was the Power of Attorney's (POA) request to not put the resident to bed before nine thirty pm, and the resident was to stay up in a wheelchair in front of the nurses station. When reviewing the clinical record there was no documentation of the interdisciplinary assessment related to the resident's preferences for waking in the mornings. There was no documentation that the POA was consulted as part of the interdisciplinary assessment related to waking the resident and getting them up and dressed between six and seven am. The PSWs confirmed they were getting the resident up between six and seven am, and they were not aware of any discussion with the POA. Reviewed the home's PSWs schedule for the night shift, which identifies each resident the night staff were expected to provide morning care and ensure the residents were up, washed and dressed before the day shift came on duty. Resident #011 was not listed as one of the residents the night shift were to wake up and get washed and dressed between six and seven am; however upon review of the home's videotape footage (Closed Caption Television - CCTV) for three days in May 2014 and observed that resident #011 was up in their wheelchair washed, dressed

and placed at the nursing station between six and seven am. Reviewed the point of care documentation by the PSWs and there was no documentation of the morning activities of daily living (ADLs), such as personal hygiene and transferring, being performed by the night shift.

B) Resident #001 is totally dependent on staff for activities of daily living (ADLs). In reviewing the clinical records there was no documentation in the plan of care to reflect that an interdisciplinary assessment occurred related to sleep patterns and preferences. The resident was washed, dressed and placed in their tilt wheelchair between six and seven am. Observed on the home's videotape footage (CCTV) for four days in May 2014 that resident was up in their tilt wheelchair dressed at approximately 6:15 am on these days. There was no documentation in the clinical record of a consultation with the POA related to the resident's preferences to be wakened this early in the morning. The home's night staff assignment identifies that the PSWs on nights were to provide morning care and get the resident up before the day staff start their shift. The documentation by the PSWs in the clinical record does not reflect the morning care by the night shift. The PSWs, RPNs and RN confirmed the resident was washed, dressed and transferred to their tilt wheelchair by the night staff and they were not aware of the resident's preferences or of any discussions the home had with the POA.

C) Resident #013 was observed washed, dressed and up in their wheelchair early each morning during the inspection in May 2014. When the POA was interviewed their preference was for the resident not to get up until 8 or 9 am as the resident was always a late riser. The POA identified that there was no consultation as to the preferences or choices of the resident. The staff confirmed the resident was washed and dressed and placed in the wheelchair by the night shift between six and seven am each day. Reviewed the home's videotape footage and noted over a seven day period in May 2014 that the resident was up in the wheelchair, washed and dressed by six thirty am. Reviewed the resident's clinical record and there was no preferences or choices noted in the plan of care. This was confirmed by the PSWs, the RPNs and the DOC. [s. 26. (3) 21.]

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 ensure the plan of care for residents must be based on, at a minimum, interdisciplinary assessment of the following with respect to residents: 21. Sleep patterns and preferences., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was developed to meet the needs of resident #011 with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The home's "Responsive Behaviours - Elopement" policy, number V3-090 and revised in March 2012 stated that all staff were responsible for identification of behavioural triggers and management of elopement. This includes: observe for any triggers of elopement or exit seeking, respond to early signs of elopement, use distraction or redirection interventions, and monitor and document. Resident #011 was exhibiting triggers of elopement and exit seeking.

The PSWs on duty in July 2013 confirmed the resident was trying to open the stairwell door, the resident was wandering in the hall in a repetitive manner near the stairwell exit and the staff tried several times to facilitate the resident going to the dining room for dinner. The PSWs stated the resident wanted to stay in that area as it was close to the resident's room, the resident did not want to go for dinner, and this was not unusual behaviour. The staff confirmed the resident had a history of exit seeking and elopement behaviours. The RPN and PSWs confirmed they did not recognize these responsive behaviours as triggers that were any different for the resident, and did not act on them. The staff confirmed they did not follow the Responsive Behaviours - Elopement policy. [s. 53. (1) 1.]

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 following is developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The POA for resident #013 stated that the preference for the resident was to get up, washed and dressed each day between eight and nine am; however based on observation and staff interviews, the resident was washed, dressed and up in their wheelchair each day by six thirty am. The quarterly assessment conducted for the resident in May 2014 did not identify the resident's preferences or choices. The resident's clinical record did not identify the resident's preferences or choices. The RNs, RPNs and PSWs confirmed they did not know what the resident's preferences or choices were, or what the POA wanted for the resident. [s. 6. (2)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

A) The plan of care for resident #011 stated the resident was to wear an identification wristband at all times. The resident was observed was over a four day period in May with no wristband. The PSWs and the RPN confirmed that the resident was to wear the wristband at all times. The clinical documentation and the assessment completed in May 2013 and May 2014 validated the resident was to wear the wristband at all times. The PSWs and the RPN confirmed that they were not following the plan of care for Resident #011.

B) The plan of care stated the resident was to have hourly checks. This was confirmed in the clinical record at the time resident #011 went missing from the home in July 2013. The primary PSW who was responsible for the resident's care on the evening shift in July 2013 confirmed in an interview that their documentation of hourly checks was inaccurate. The PSW confirmed that hourly safety checks were not conducted for resident #011 in July 2013. In addition, the RPN and the Administrator confirmed that

the PSW did not conduct hourly safety checks on the evening shift the resident went missing in July 2013. The clinical record review of the resident's most recent assessment in May 2014 confirmed that hourly safety checks were not being conducted for resident #011. This was also confirmed by the PSWs, the RPNs and the Administrator. The PSWs, the RPNs and the Administrator confirmed that they were not following the plan of care for Resident #011.

C) The most recent plan of care of May 2014 stated that resident #011 was to have a chair alarm on at all times when they are up in the wheelchair. Resident #011 was observed in May 2014 in the wheelchair with no chair alarm. The resident was observed trying to get out of the wheelchair to walk. Review of the clinical record confirmed the resident was to have the chair alarm on while in the wheelchair for safety as the resident was high risk for falls. Confirmed with the RPN and the PSWs that the resident was to have a chair alarm on at all times while in the wheelchair. Confirmed with the PSWs and the RPNs that they were not following the plan of care for Resident #011.

D) The plan of care stated that if resident #011 was restless and attempting to get out of the wheelchair that two staff were to assist the resident to stand and take them for a short walk, then re-try settling the resident into the wheelchair. It was confirmed with the PSWs and the RPN that they were to implement this intervention in order to help reduce the resident's restlessness and agitation. Staff confirmed they don't consistently implement this intervention for the resident. The resident was observed in May 2014 attempting to get out of the wheelchair, was restless and agitated. Staff did not assist the resident and take them for a short walk, as specified in the plan of care. Confirmed with the PSWs and the RPNs that they were not following the plan of care for Resident #011. [s. 6. (7)]

Issued on this 15th day of October, 2014

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