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, 2014	2014_275536_0025	H-001208-14	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

CATHIE ROBITAILLE (536)

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): September 29, 30, October 3, 6, 7, 8, 2014

During the course of the inspection, the inspector(s) spoke with residents, family, regulated and unregulated workers, Registered staff, Associate Director of Care (ADOC), Director of Care and Executive Director(ED)

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and

friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents’ Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents’ Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in

order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #100 was properly cared for in a manner consistent with his or her needs.

On an identified date in 2014 resident #100 returned from the hospital following a fall with injury. A report was not received by the home until an identified date in 2014 identifying that the resident had an identified fracture as well as another identified diagnosis. Resident #100 who suffers from advanced dementia was exhibiting signs of pain following their return from the hospital. The resident could not always identify the area where the pain was however, when questioned often agreed it was lower back pain. Between identified dates in 2014 resident #100 was also being treated for an above average temperature. The resident had a history of Urinary Tract Infections (UTI's). The home did do a urinalysis on an identified date in 2014 however, the results were inconclusive and another specimen was not collected until later on an identified date in 2014. The ultrasound to determine if the identified condition was acute and potentially a contributing factor to the resident's symptoms was not completed for seven days despite the families numerous voiced concerns.

The home failed to properly care for resident #100 when the physician was not informed of the hospital report results and the residents increased temperature until 3 days later. The urinalysis was not repeated for twelve days. [s. 3. (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 and ensuring that residents are properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer necessary.

Resident #100's plan of care which the home refers to as the care plan indicated the resident was to wear a neck collar to stabilize the neck. The care plan also indicated that the resident often refused to wear the collar. The Registered staff confirmed that resident #100 no longer wore the neck collar and it was no longer in the home. The Registered staff also confirmed that the use of the neck collar should have been removed from the care plan.

B) Resident #100 had been placed on heightened monitoring of every fifteen minute while in wheelchair or when using walker as the resident would often attempt to walk unsupervised, without the walker or wheelchair. The resident had a Walker/Wheelchair Monitoring checklist in place which required staff to check on resident every fifteen minutes. The Kardex which directs the Personal Support Workers (PSW's) identified that the resident was to have hourly safety checks. The PSW's and Registered Staff confirmed resident was checked every 15 minutes not every hour. The Director of Care (DOC) confirmed the information regarding hourly safety checks in the kardex was

incorrect, and that she was aware of this problem and was working with the software provider to rectify this. [s. 6. (10) (b)]

2. The licensee failed to ensure that resident #100’s substitute decision maker was given an explanation of the plan of care.

On an identified date in 2014 the home received a report from the hospital in regards to resident #100’s recent hospital visit following a fall. On that same date, a family member of resident #100 was in to visit. The Associate Director of Care (ADOC), was asked if the hospital report had been received. The ADOC told the resident’s family member that it had arrived and asked if they would like a copy. The family member agreed and the ADOC provided them with a copy which they said they would share with family. The ADOC did not give a detailed report of the findings to the family member assuming that the Registered Practical Nurse (RPN) who had received the report earlier in the day had contacted the Power of Attorney (POA). Three days later on an identified date in 2014, the POA came into the home as they were concerned about the resident's current health status and was told at that time that the resident had an identified diagnosis. The POA asked for an explanation as they were unaware of this diagnosis, as the hospital report had not yet been provided to them.

B) Resident #100 also had a history of Urinary Tract Infections (UTI’s) and had routinely ordered urinalysis. Due to the increased temperature and pain the resident was experiencing and the families voiced concerns, the urinalysis was done on an identified date in 2014 as opposed to the routine test ordered for a later date. The home was advised of the results on an identified date in 2014 and made the decision based on the laboratory results stating specimen was contaminated to do a repeat urinalysis however, the POA was not notified. The second urinalysis was completed on an identified date in 2014 with results received. Antibiotic treatment was order and the POA was called at that time for approval of treatment with Antibiotics. Due to the voiced concerns of the family the results of the first laboratory report on an identified date in 2014 should have been communicated to the POA at the time the results were received. [s. 6. (12)]

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 residents are reassessed and the plan of care reviewed and revised when care needs change and that substitute decision makers are given an explanation of the plan of care, to be implemented voluntarily.

Issued on this 10th day of December, 2014

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

Original report signed by the inspector.