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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2013	2013_208141_0019	H-000303-13	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

SHARLEE MCNALLY (141)

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): July 10, 11, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), and residents

During the course of the inspection, the inspector(s) reviewed resident's records; home's investigation summary of incident, complaint log, policies and procedures, and staff work schedules

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

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:
2. Every resident has the right to be protected from abuse. 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 resident #001 was protected from abuse.
The resident stated that in May, 2013 a staff person caused an injury by attempting to forcefully remove equipment from them. The resident further stated previous to this the staff person had provided care as per their identified preference when requested. The resident having increased pain after the incident. The home's investigation summary stated the resident was tearful when giving their statement.
The home investigation of the incident resulted in the staff person being disciplined for attempting to remove the call bell from the resident when the resident resisted. [s. 3. (1) 2.]

2. The licensee did not fully respect and promote resident #001 right to have his lifestyle and choices respected.
A) The resident had expressed at time of admission their choice in daily routines. The home did not assess the resident to identify the time and frequency the daily routine needed to be completed. Staff who provided care to the resident stated they suspected the reason for the resident the preference in routine. The staff did not ensure that the choice related to this daily routine was care planned. The resident stated staff did not follow the routine consistently.
B) The resident expressed an allegation of abuse by staff to the home in May, 2013. The home completed an investigation. The resident had expressed their choice of not having the staff involved in the incident caring for them in the future. The Administrator and DOC confirmed they were aware of the resident's choice for not having the identified staff working with them but had not implemented any change. Review of the home's schedule identified the staff had continued to care for the resident for 12 shifts since the identified incident up to and including the inspection period. [s. 3. (1) 19.]

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 resident has the right to be protected from abuse, have his or her lifestyle and choices respected., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #001 from abuse by staff in the home.
The resident alleged that a staff member forcefully removed a piece of equipment from and refused to provide care related to their expressed preference. The home completed an investigation into the allegation and confirmed the incident occurred.
The staff person, who was disciplined, had a previous allegation by another resident in 2013 stating the same staff person had refused to provided care and assistance and was rough in providing care causing pain. The home investigated the incident.
Review of the identified staff personnel record identified the staff person received a previous non disciplinary letter related to Resident's Rights violation in 2012.
The home failed to monitor staff performance or implement actions to ensure the staff person did not neglect or abuse residents while providing care. [s. 19. (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 residents are protected from abuse by anyone and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that their policy to promote zero tolerance of abuse and neglect was complied with.
The home's policy "Abuse and Neglect Resident" (V3-010), last revised February 2012, stated if any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take steps:
c) immediately inform the Director of Administration and/or charge nurse in the home.
The resident was observed with an injury in May, 2013. The resident reported to the registered nursing staff the injury was caused by a staff person three days previously. The resident's allegation was documented in the resident's progress notes.
An allegation of abuse related to resident #001 was not reported to the home's Administrator immediately. The Administrator confirmed the home was unaware of the allegation until six days after staff were made aware of the allegation. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, 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:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Resident #001 plan of care was not based on an interdisciplinary assessment of the resident's cultural, spiritual and religious preferences.
The resident was admitted in October, 2012. The Resident's Leisureworld Program Initial Assessment completed two days later identified the resident as being of an identified religion and had daily routines related to the identified religion. There was no further assessment to identify how the home could meet the resident's daily routine needs. The resident identified they preferred to be up each day to perform the routine but this preference was not respected consistently by staff assisting them with care.
The resident's written plan of care did not identify the resident's preference for time and frequency of the daily routine until May, 2013 after a reported incident by the resident. [s. 26. (3) 22.]

Issued on this 2nd day of August, 2013

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