Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 18, 28, 2011	2011_027192_0008	Other

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 - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Recreation Assistants.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, observed care and activities.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Housekeeping

Residents' Council

Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

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 sayants :

1. Concerns of the Resident's Council are not consistently responded to within 10 days.
A review of the minutes of Resident's Council demonstrated the following:
March 25, 2011 meeting
Personal Support Workers (PSW's) are leaving residents on the toilet and walking away for extended periods of time - no response.
January 28, 2011 meeting:
Night staff meeting/talking can be too loud and wake up residents - no response
Dining rooms running out of cups saucers and cutlery - not always set up prior to mealtime - no response
Resident's on heritage side of building not happy with the new seating arrangements and prefer the old seating plan - no response.
Gardenview Dining Room - ceiling tiles appear worn and concern they could fall - no response.
Resident's are finding their beds are not made on time in the mornings - no response
February 22, 2011
D-7 call bell not working - no response.

During interview with the president of Resident's Council, it was confirmed that the Resident's Council does not consistently receive a response in writing for all concerns/complaints made through Resident's Council. He also expressed concern at the number of times concerns are repeated at Resident's Council without action from the home. .
e.g. Night staff are too loud and wake residents appears in the minutes of Resident's Council on January 28, 2011; February 22, 2011 and March 25, 2011.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

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;
(b) cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits sayants :

1. Lingering odors are evident throughout the day in the vicinity of Washroom #1 and Room # 2. The odour extends down the hall in all directions and is consistently present as confirmed during inspection conducted April 18, and 19, 2011.
Odours were noted on arrival April 18 at 0930, at 1330 and again at 1900 hours.
Odours were present April 19, 2011 at 0930, 1100 and 1230.

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 ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits sayants :

1. Staffing schedules were reviewed for the time period between March 3, 2011 and April 13, 2011.
It is noted that during the day shift, the home worked short at least one Personal Support Worker 36% of the time (15/42), on evenings the home worked short at least one Personal Support Worker 43% of the time (18/42) and on nights the home worked short at least one Personal Support Worker 16% of the time (7/42).
Over the period reviewed - 6 weekends are included - 100% of the weekends reviewed had a least one shift reporting shortages in staffing. For 50% of the weekends reviewed, the home was short Personal Support Workers on all three shifts.
Residents interviewed indicated that they frequently miss their baths due to staff shortages related to call-ins.
One resident interviewed indicated that the home frequently goes into a shift knowing they will be short Personal Support staff and then there will be a further call-in or no-show and staffing and care are further impacted.
Staff interviewed confirmed that staffing shortages occur on most weekends and the practice has been to pull the bath nurse in order to cover other duties. Baths are frequently not completed within the week.
The bathing records for 6 residents were reviewed. Only two of these residents received two baths per week and not always consistently.
During interview the Administrator indicated that the home currently has 12 empty beds and has not been replacing the first two call-ins on the day shift, but do replace evening and night shifts. In spite of this statement it is noted that the evening shift worked short 43% of the time between March 3 and April 13, 2011 and were short of Personal Support (PSW) staff 5 of 6 of weekends reviewed. It is noted on March 19, 2011 during the evening the home worked short 5 PSW's and on March 20, 2011 during the evening worked short 4 PSW's. On several other occasions the home worked short two or three PSW's during the evening shift.
A review of the Resident's Council minutes indicate that during the March 25, 2011 Resident's Council meeting residents were concerned that the Personal Support Workers were leaving residents on the toilet and walking away for extended periods of time. At the January 28, 2011 Resident's Council meeting residents expressed concern that call bells were not being answered in a timely manner.
The current back-up plan is ineffective in addressing the needs of the residents when staff cannot come to work.

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 ensuring the home has in place a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work, 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 subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits sayants :

1. A specified resident has a plan of care related to responsive behaviours. The plan of care does not include a description of how the behaviours are exhibited by this resident or triggers that may initiate the behaviours identified.
During interview a Recreation Assistant indicted that behaviours exhibited by this resident are unpredictable and can occur very quickly. Specific triggers for the behaviours could not be identified.

Issued on this 8th day of June, 2011

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

Debora Saville