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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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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
Jul 16, 2015	2015_188168_0011	H-000988-14	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 - BRANTFORD
389 WEST STREET BRANTFORD ON N3R 3V9

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

LISA VINK (168)

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): onsite April 21, 22 and 30, 2015, and May 1, 4, 8 and 29, 2015.

This inspection was conducted concurrently with Critical Incident inspections H-002202-15 and H-002131-15. Findings of non-compliance related the concurrent inspections are included in this Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the current and past physiotherapists, staff from the office of an Orthopedic Surgeon, registered nursing staff, personal support workers (PSW's) and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
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 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. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's Fall Prevention Program, V3-630, last revised November 2013, identified the post fall procedure that registered staff would "document the initial physical assessment; and complete and document a head to toe assessment at least q shift x 3 days following a fall", lead a post falls huddle with the purpose to "identify the root cause of the fall, look for contributing factors and trends, and identify interventions that can mitigate future risk" to be documented in the electronic health record and that the registered nurse was to complete the following documentation "refer to physiotherapy".

A. Resident #02 sustained a total of five falls over a 32 day period. The falls prevention and management program was not consistently complied with as required post fall.
i. The resident did not have a head to toe assessment completed and documented every shift for three days following the first and second fall. Assessments were not documented on three of the nine required shifts for the first fall and for the first two shifts immediately following the second fall, as confirmed by staff interview during a clinical record review.
ii. The resident did not have a referral and/or assessment by physiotherapy following the first or second fall as confirmed during a clinical record review and interview with registered staff, despite the fact that there was consent in place for the assessments to be completed.
iii. The resident had a post fall assessment and huddle completed following each of the identified falls. A review of the post falls documentation and the plan of care did not include identification of interventions that may mitigate future risk. Interview with registered staff confirmed that a number of medication changes had been made to the medical regime; however, they were not identified to be done in relation to the management of falls. The staff confirmed that the documentation did not include identification of interventions that may mitigate future risk.

B. Resident #06 sustained an unwitnessed fall in 2015. The resident was immediately assessed post fall and provided care as required. The resident did not have a documented assessment completed post fall each shift for three days. The resident did not have post fall notes completed for the second, fifth, sixth, eighth and ninth shifts post fall and neurological vital signs were not documented as completed for the seventh, eighth, ninth, tenth, and eleventh checks as confirmed during a record review with registered staff.

C. Resident #01 sustained six falls from May until October 2014. The resident did not have a head to toe assessment completed and documented every shift for three days following each fall, nor did documentation include identification of interventions that may mitigate future risk.
i. Following the first fall, assessments were not documented for six of the nine required shifts post fall, nor did documentation include identification of interventions to mitigate future risk.
ii. Following the second fall, which resulted in an injury requiring surgical intervention, documentation did not include identification of interventions to mitigate future risk.
iii. Post fall assessments were not documented following the fourth fall for eight of the nine required shifts, nor did documentation include identification of interventions to mitigate future risk.
iv. Post fall assessments were not documented following the fifth fall for five of the required nine shifts, nor did documentation include identification of interventions to mitigate future risk.
v. Following the sixth fall, assessments were not documented for four of the required nine shifts, post fall.
Record review with registered staff and interview with the DOC confirmed that the Falls Prevention Program was not complied with as identified above for resident #01. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident provided clear directions to staff and others who provided direct care to the resident.

A. The plan of care for resident #07 identified under transfers, two staff extensive physical assist with hoyer lift. The bed side lift logo identified that the resident was a one person transfer.
On May 1, 2015, the resident was observed being transferred with the use of a sit to stand lift and two PSW's.
Interview with one of the PSW's who assisted in the lift confirmed the use of the sit to stand lift and identified that the resident recently had a change in condition and was no longer able to assist with transfers using a mobility aid and for this reason a lift was used.

The PSW identified that at times a sit to stand was used or a hoyer, it was based on the status of the resident that day and/or the staff working.
Interview conducted with registered staff confirmed that the bed side logo should be updated with the plan of care and that the plan noted the use of a hoyer lift.
Interview with the charge nurse confirmed that the resident had a change in condition and for that reason a mechanical lift was required. She confirmed that the needs of the resident vary and at times a sit to stand lift was appropriate while at others a hoyer. She noted that the home allowed staff to increase the assistance provided to a resident based on their needs for safety. The charge nurse reviewed the plan of care and confirmed that it did not give clear direction related to the transfer techniques available and to be used by the resident and staff.

B. Resident #01 was admitted to the home with a brace to be worn to the ankle due to an identified need for support, safety and comfort. This device was changed to an air boot, which staff were required to inflate and deflate, following an injury for two weeks in the summer of 2014, before a plaster cast was reapplied. Once the cast was removed the air boot was re-initiated for approximately one month before it was replaced with a standard brace. The plan of care did not provide clear direction to staff and others who provided direct care to the resident related to the use of the air boot. The plan of care did not give clear direction regarding how to use/apply the air boot, which was to be inflated with a pump to a specific volume of air and deflated before removal, until the second time that the device was prescribed, as confirmed during an interview with registered staff.

C. The plan of care for resident #02 did not provide clear direction related to level of

assistance with toileting, mobility and use of mobility aids and the use of a treatment to increase fluid intake.
i. The plan identified under bowel continence that the resident was able to toilet self; under activities of daily living - toilet use, that they required limited assistance and under high falls risk and that they were on a toileting plan to reduce urgency. Staff interviewed indicated that the resident continued to toilet independently; however, for safety considerations this was not desired and that staff attempted to provide/offer assistance. Interview with registered staff confirmed that the plan of care was not consistent regarding level of care required for toileting.
ii. The plan of care under high falls risk noted efforts to use a wheelchair when restless and unsteady; under programs that they could walk independently to and from program area and under limited physical mobility that they required one staff supervision and set up for mobility. Interview with PSW and registered staff confirmed that the resident continued to walk independently, although staff encouraged the use of a walker. The use of the walker was not included in the plan as confirmed by registered staff who also verified that the plan of care did not give clear direction related to mobility and use of devices.
iii. The plan of care noted that the resident was on a treatment to improve fluid intake for three days and records identified the day the treatment was initiated and discontinued. The discontinued date was 17 days after the date of initiation. Registered staff interviewed identified that the treatment length was not 17 days, that it was discontinued the day it was initiated due to an incident which lead to transport to hospital. Staff interviewed confirmed that the plan did not give clear direction related to the use of the treatment. [s. 6. (1) (c)]

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 written plan of care for each resident provides clear directions to staff and others who provide direct care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #01 was admitted to the home using an ankle support. The resident continued to require a device to the ankle which staff were required to apply and remove daily, with the exception of during a six week period of time following an injury and a second period of time, approximately one month in length, when a cast was in place. Staff did not document the application or removal of the device(s) until included onto the electronic Treatment Administration Record in November 2014. Interview with registered staff confirmed that the application and removal of the device(s) were not documented and that this information should be included in the clinical record. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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

Issued on this 16th day of July, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8	Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2015_188168_0011
Log No. / Registre no:	H-000988-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2015
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRANTFORD 389 WEST STREET, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelly Desgagne

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where the Act or this Regulation requires the licensee 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 is complied with, specifically related to the management of falls.

This plan shall include but not be limited to:
a. a review of the home's Fall Prevention Program to ensure that it provides clear direction to staff
b. re-education of front line staff regarding the program and its requirements
c. a system or process to audit falls in the home for the necessary requirements under the program to be utilized until staff are compliant with the program (as determined by the home to set the audit schedules, frequency and completion time frame).

The plan is to be submitted to Lisa.Vink@ontario.ca by July 29, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's Fall Prevention Program, V3-630, last revised November 2013, identified the post fall procedure that registered staff would "document the initial

physical assessment; and complete and document a head to toe assessment at least q shift x 3 days following a fall", lead a post falls huddle with the purpose to "identify the root cause of the fall, look for contributing factors and trends, and identify interventions that can mitigate future risk" to be documented in the electronic health record and that the registered nurse was to complete the following documentation "refer to physiotherapy".

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i. The resident did not have a head to toe assessment completed and documented every shift for three days following the first and second fall. Assessments were not documented on three of the nine required shifts for the first fall and for the first two shifts immediately following the second fall, as confirmed by staff interview during a clinical record review.
ii. The resident did not have a referral and/or assessment by physiotherapy following the first or second fall as confirmed during a clinical record review and interview with registered staff, despite the fact that there was consent in place for the assessments to be completed.
iii. The resident had a post fall assessment and huddle completed following each of the identified falls. A review of the post falls documentation and the plan of care did not include identification of interventions that may mitigate future risk. Interview with registered staff confirmed that a number of medication changes had been made to the medical regime; however, they were not identified to be done in relation to the management of falls. The staff confirmed that the documentation did not include identification of interventions that may mitigate future risk.

B. Resident #06 sustained an unwitnessed fall in 2015. The resident was immediately assessed post fall and provided care as required. The resident did not have a documented assessment completed post fall each shift for three days. The resident did not have post fall notes completed for the second, fifth, sixth, eighth and ninth shifts post fall and neurological vital signs were not documented as completed for the seventh, eighth, ninth, tenth, and eleventh checks as confirmed during a record review with registered staff.

C. Resident #01 sustained six falls from May until October 2014. The resident did not have a head to toe assessment completed and documented every shift for three days following each fall, nor did documentation include identification of

interventions that may mitigate future risk.
i. Following the first fall, assessments were not documented for six of the nine required shifts post fall, nor did documentation include identification of interventions to mitigate future risk.
ii. Following the second fall, which resulted in an injury requiring surgical intervention, documentation did not include identification of interventions to mitigate future risk.
iii. Post fall assessments were not documented following the fourth fall for eight of the nine required shifts, nor did documentation include identification of interventions to mitigate future risk.
iv. Post fall assessments were not documented following the fifth fall for five of the required nine shifts, nor did documentation include identification of interventions to mitigate future risk.
v. Following the sixth fall, assessments were not documented for four of the required nine shifts, post fall.
Record review with registered staff and interview with the DOC confirmed that the Falls Prevention Program was not complied with as identified above for resident #01. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office