**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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l’inspection | Log # / Registre no | Type of Inspection / Genre d’inspection |
|---|---|---|---|
| Jul 21, 2015 | 2015_344586_0010 | H-002632-15 | Resident Quality Inspection |

**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**

JESSICA PALADINO (586), LESLEY EDWARDS (506), YVONNE WALTON (169)

## Inspection Summary/Résumé de l’inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): June 22, 23, 24, 25, 26, 29 and July 6, 7, 8, 2015.**

**The following inspections were completed during simultaneously with this Resident Quality Inspection;**
**Follow-up Inspection: H-002196-15.**
**Complaint Inspections: H-001450-14, H-001582-14, H-001652-14, H-001722-14, H-002228-14, H-002293-15 and H-002458-15.**
**Critical Incident Inspections: H-001848-15 and H-002147-15.**

**During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Director of Dietary Services (DDS), Office Manager, Resident Relations Coordinator (RRC), Director of Resident Program and Admissions, Physiotherapist, dietary aides, housekeeping and maintenance staff, personal support workers (PSWs), Registered nurses (RNs), Registered practical nurses (RPNs), recreation staff, residents and family members.**

**During the course of the inspection, the inspector(s) toured the home; observed residents in dining areas and care areas; reviewed policies and procedures; resident health records; the home's internal investigation notes and staff schedules.**

**The following Inspection Protocols were used during this inspection:**

**Admission and Discharge**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**
**Training and Orientation**

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

**11 WN(s)**
**6 VPC(s)**
**2 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home had a procedure "Continence Bowel - Prevention of Constipation Home Specific Procedure, V3-240.1, last revised Aug 16, 2013", which directed registered staff to administer 125 ml of prune juice if the resident did not have a bowel movement (BM) for two days, then administer 30 ml of Milk of Magnesia (MOM) if no BM for 3 days, if no BM for four days administer a Dulcolax suppository and if still no BM for five days administer a Fleet enema and notify the physician.

A review of the clinical records for the following residents identified that staff did not consistently comply with the home’s procedure:
i. Resident #119 did not receive the interventions in accordance with the home’s policy on three occasions in June 2015.
ii. Resident #004 did not receive the interventions in accordance with the home’s policy on two occasions in June 2015.
iii. Resident #104 did not receive the interventions in accordance with the home’s policy on three occasions in June 2015.
iv. Resident #108 did not receive the interventions in accordance with the home’s policy on three occasions in June 2015.

An interview was conducted with registered staff on July 8, 2015, which confirmed that the home’s procedure was not complied with. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training**

**Specifically failed to comply with the following:**

**s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff who work pursuant to a contract between the licensee and an employment agency in accordance with section 2(1)(c) of the Act were provided information on the Resident's Bill of Rights, policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports, whistleblowing protection, fire prevention and safety, emergency and evacuation procedures and infection control before providing their services in accordance with section 79(2) of the Act.[s.222(2)]

A review of the home's staffing schedules and monthly quality indicator records confirmed that the home used 20 hours of agency PSWs in April 2015, seven hours in May 2015, and 38.5 hours in June 2015, as well as 216 hours of agency registered staff in April 2015, 150.25 hours in May 2015, and 156.5 hours in June 2015.
i. The home's policy "Orientation" [policy identifier: V4-240, revised April 2012] stated that agency staff shall receive four hours orientation prior to providing care within the home. Agency staff would also receive a one page reference sheet outlining key information at that particular home.
i. Interview with an agency PSW working on the day shift during the inspection confirmed that an orientation checklist or one page reference sheet was not provided to them prior to starting work in the home and that there was no formal orientation given.
ii. A complaint received from a staff member during the inspection indicated that agency staff were not trained on the home's policies and procedures.
iii. Interview with the ADOC confirmed that the home did not currently have a formal orientation or training program for agency staff, and that four hours of orientation as noted in the policy was not provided. The ADOC also confirmed that they do not provide the agency staff information related to the Resident's Bill of Rights, policy to promote zero tolerance for abuse, duty to make mandatory reports, whistle-blowing protection, fire prevention and safety, emergency evacuation procedures and infection prevention and control prior to providing service in the home. [s. 222. (2)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #104 so that their assessments are integrated, consistent with and complement each other.

Resident #104 was admitted to the home on an identified date in February 2015 with a history of urinary retention and developed constipation requiring frequent laxatives. The resident also developed sexually inappropriate behaviours after admission to the home. The Psycho-geriatric Resource Consultant (PRC) at the Alzheimer's Society completed an assessment on an identified date in May 2015 and made recommendations for pharmacological review by the pharmacist; however, this was not completed. The PRC also recommended the resident be put on a regular toileting schedule to assist with urinary continence and to monitor for urinary retention. This would also assist with regular bowel movements and reduced the use of laxatives resulting in bowel incontinence. The assessment and recommendations by the PRC were not integrated by staff involved in the care of the resident. This was confirmed by the clinical documentation, ADOC and ED. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

Resident #004’s plan of care indicated that the resident was to use a chair alarm while in their chair to help mitigate the risk for falls. An observation of the resident on June 24, 2015, confirmed that the resident was not using a chair alarm while in their chair. Interview with the nursing staff on June 24, 2015, confirmed that the resident was no longer using the chair alarm for the past six or seven months. The ADOC confirmed that the plan of care should have been reviewed and revised as the care set out in the resident’s plan changed. [s. 6. (10) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #104 and all residents so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing.

i. On June 23, 2015, in the afternoon, residents #009 and #014 were observed in the front hallway with their pajamas on. The residents were unable to state their preferred clothing, or if they were uncomfortable with their attire. The registered staff member was unable to tell the inspector why the residents were in their pajamas prior to the dinner meal.
ii. On June 25, 2015, in the afternoon, residents #112, #113 and #008 were observed in the front hallway with their pajamas on. The residents were unable to state their preferred clothing, or if they were uncomfortable with their attire. The registered staff member was unable to tell the inspector why the residents were in their pajamas prior to the dinner meal however; stated, they thought the residents were scheduled for a bath. A review of the bath schedule confirmed that these residents were not scheduled for baths and the residents' plans of care did not include being placed in their night time attire prior to the dinner meal as the residents' preferences. [s. 40.]

***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 each resident of the home is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home**

**Specifically failed to comply with the following:**

**s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant’s admission to the home unless,**
**(a) the home lacks the physical facilities necessary to meet the applicant’s care requirements; 2007, c. 8, s. 44. (7).**
**(b) the staff of the home lack the nursing expertise necessary to meet the applicant’s care requirements; or 2007, c. 8, s. 44. (7).**
**(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when the appropriate placement co-ordinator gave the licensee selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee reviewed the assessments and information, the applicant's admission to the home was approved, unless the (b) staff of the home lack the nursing expertise necessary to meet the applicant's care requirement.

Residents #100 and #101 were assessed by Community Care Access Centre (CCAC) and determined to be eligible for admission to the home. Copies of the assessments and information were provided to the home on two identified dates in October 2014 by the placement co-ordinator. Both resident assessments were reviewed by the Director of Resident Program and Admissions and DOC and letters of refusal were sent to each of the applicants, CCAC and the Ministry of Health. The letters identified the reason for the refusals. Interview with the ED, DOC, ADOC and the RRC confirmed the home has Registered Nursing staff who are trained in the identified medical procedure and there are sufficient registered staff to manage this. Currently the home has one resident with the identified medical device and there is one resident with this device on the waiting list for admission. [s. 44. (7) (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 with LTCHA, 2007 s.44(7), whereby the licensee does not refuse an applicant's admission to the home based on reasons that are not permitted within the legislation, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when resident #006 was exhibiting a pressure ulcer, they received immediate treatment and interventions to promote healing and prevent infection.

i. Resident #006 was identified as having a wound on an identified date in February 2015. Record review indicated that the resident's wound was not immediately treated and interventions were not developed to promote wound healing and prevent infection.
ii. Resident #006 had a wound assessment completed on an identified date in February 2015, 14 days later, and it was documented that the wound had increased in size and the wound again was not treated nor interventions developed.
iii. Resident #006's record review confirmed that the wound was not assessed again until 21 days later, and at this time treatment orders were obtained and interventions were developed, when the ulcer worsened and became infected. [s. 50. (2) (b) (ii)]

***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 every resident exhibiting a pressure ulcer receives immediate treatment and interventions to promote healing and prevent infection,., to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:**
**5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an annual evaluation of residents' satisfaction

with the range of continence care products in consultation with residents, substitute decision makers (SDM) and direct care staff, was completed.

During a review of the home's continence care program and annual evaluation it was noted that there had not been an annual evaluation completed by the residents, SDM's or direct care staff in regards to the satisfaction with the home's current continence care products. The ADOC could not recall the exact date the last annual satisfaction survey was completed; however, thought it could have been sometime in 2013. The ADOC did not have the results of the satisfaction survey at the home. [s. 51. (1) 5.]

2. The licensee has failed to ensure that resident #104 received an incontinence assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #104 had a history of having a catheter for several years prior to admission. The resident was admitted to the home after a hospitalization due to urinary complications and the discharging physician identified urinary diagnosis that could make the resident agitated. While at the home, urinary retention had not been assessed and the resident did demonstrate symptoms related to this diagnosis. The resident had a significant medical history related to urinary incontinence and this was not assessed by the home. This was confirmed by the clinical record, ADOC, and ED. [s. 51. (2) (a)]

3. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) The April 2015 Minimum Data Set (MDS) Assessment for resident #010 indicated the resident was incontinent of bladder and bowel all of the time. A review of the resident's plan of care, Resident Assessment Protocol (RAP) and written care plan, did not include measures to promote and manage bladder and bowel incontinence. Interview with the ADOC on July 7, 2015, confirmed resident #010 did not have an individualized plan, as part of their plan of care, to promote and manage bladder and bowel incontinence. (506)

B) The June 2015 MDS Assessment for resident #117 indicated the resident was frequently incontinent of bowel and incontinent of bladder all of the time. Interview with a PSW who regularly provided care for the resident indicated that the resident almost

always had a bowel movement at a specified time during the day, and confirmed that this was not included in the resident's plan of care. A review of the resident's plan of care did not include any information on the resident's bowel habits, nor did the plan of care, RAP and written care plan include any measures to promote and manage bladder and bowel incontinence.

C) The May 2015 MDS Assessment for resident #118 indicated the resident was frequently incontinent of bladder and continent of bowel. Interview with a PSW who regularly provided care for the resident indicated that almost every day, the resident would have bowel movements at specified times, and confirmed that this was not included in the resident's plan of care. A review of the resident's plan of care did not include any information on the resident's bowel habits, nor did the plan of care, RAP and written care plan include any measures to promote and manage bladder and bowel incontinence. (586)

D) Resident #104 had a history of having an indwelling catheter for several years prior to admission to the home. Upon admission to the home on an identified date in 2015, the plan of care for the resident did not include interventions to monitor the catheter. The resident developed sexually inappropriate behaviours after admission to the home. The resident also developed constipation and required frequent use of laxatives. The plan of care did not include an individualized plan of care to promote bowel continence. This was confirmed by clinical documentation, the ADOC, and ED. (169) [s. 51. (2) (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 resident #104 and every resident receives an incontinence assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument; as well as to ensure that each resident who is incontinent has an individualized plan, as per of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the advice of the Residents’ Council was sought out in developing and carrying out the satisfaction survey.

Interview by Inspector #169 with the Residents’ Council President on June 24, 2015, confirmed that the advice of the Council was not sought out in developing and carrying out the home’s annual satisfaction survey. In an interview with the ED, she stated that the home purchased a predetermined survey and confirmed that because the survey could not be edited, the residents did not have input into the survey questions. [s. 85. (3)]

***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 advice of the Residents' Council is sought out in developing and carrying out the annual satisfaction survey, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**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,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On June 6, 2015, resident #004's restraint was observed to be very soiled with old food stains and dried spills. This was confirmed by the PSW and ADOC, who indicated that the evening PSW staff were to clean the restraint when needed. The resident was observed again on June 7, 2015, and the restraint remained dirty and had not been cleaned. [s. 87. (2) (b)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that medications were stored in a medication cart that was secure and locked.

On an identified date in June 2015, the medication cart was left unattended and unlocked outside of the dining room and the registered staff member was in the dining room. The Inspector was able to open the drawers of the medication cart. The ADOC confirmed that the medication cart was left unlocked and unattended. [s. 129. (1) (a) (ii)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

The following were observed:
i. On June 22, 2015, a used bar of soap, several unlabelled deodorants, combs and brushes with hair in them were found on the shelf in the spa room on the Elmwood home area.
ii. On June 22, 2015, used combs and brushes with hair found in them and used unlabelled deodorants were found on the shelf in the spa room on the Beachwood home area.
The ADOC confirmed that all personal items are to be labelled. [s. 229. (4)]

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**Issued on this 22nd day of July, 2015**

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

**Original report signed by the inspector.**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

## Ordre(s) de l'inspecteur

Aux termes de l'article 154 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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JESSICA PALADINO (586), LESLEY EDWARDS (506), YVONNE WALTON (169) |
| **Inspection No. / No de l'inspection :** | 2015_344586_0010 |
| **Log No. / Registre no:** | H-002632-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jul 21, 2015 |
| **Licensee / Titulaire de permis :** | 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP<br>302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | LEISUREWORLD CAREGIVING CENTRE - BRANTFORD<br>389 WEST STREET, BRANTFORD, ON, N3R-3V9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Susan Hastings |

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) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2015_188168_0004, CO #001;

**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 ensure that the home's procedure "Continence Bowel - Prevention of Constipation Home Specific Procedure, V3-240.1, last revised Aug 16, 2013", or any revisions to this procedure or replacement procedure, approved on or before September 1, 2015, 2015, are complied with by staff in the home to prevent constipation.
Specifically, this process shall include but not be limited to:
A) The education of all staff responsible for complying with the procedure, related to the procedure expectations, the importance of compliance and risks related to constipation.
B) The implementation of a system to monitor and evaluate compliance with the procedure on an ongoing basis.
C) The implementation of a system to evaluate the process staff follow in day to day use of the procedure with nursing and dietary staff.

**Grounds / Motifs :**

1. This area of non-compliance was previously served as a Compliance Order (CO) most recently in February 2015.

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

The home had a procedure "Continence Bowel - Prevention of Constipation Home Specific Procedure, V3-240.1, last revised Aug 16, 2013", which directed registered staff to administer 125 ml of prune juice if the resident did not have a bowel movement (BM) for two days, then administer 30 ml of Milk of Magnesia (MOM) if no BM for 3 days, if no BM for four days administer a Dulcolax suppository and if still no BM for five days administer a Fleet enema and notify the physician.

A review of the clinical records for the following residents identified that staff did not consistently comply with the home's procedure:
i. Resident #119 did not receive the interventions in accordance with the home's policy on three occasions in June 2015.
ii. Resident #004 did not receive the interventions in accordance with the home's policy on two occasions in June 2015.
iii. Resident #104 did not receive the interventions in accordance with the home's policy on three occasions in June 2015.
iv. Resident #108 did not receive the interventions in accordance with the home's policy on three occasions in June 2015.

An interview was conducted with registered staff on July 8, 2015, which confirmed that the home's procedure was not complied with. [s. 8. (1) (b)] (586)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 01, 2015

**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

**Order / Ordre :**

The licensee shall ensure that staff who work pursuant to a contract between the licensee and an employment agency in accordance with section 2(1)(c) of the Act are provided information on the Resident's Bill of Rights, policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports, whistleblowing protection, fire prevention and safety, emergency and evacuation procedures and infection control before providing their services in accordance with section 76(2) of the Act.
Specifically, the home shall ensure:
A) The development of an orientation program for all agency staff scheduled to work in the home, including an orientation checklist to ensure each staff member's training completion.
B) All agency staff scheduled to work in the home have received appropriate orientation to the home that meets the legislative requirement.
C) The home's policy "Orientation, V4-240, last revised April 2012", or any revisions to this procedure or replacement procedure, approved on or before September 1, 2015, 2015, are complied with.

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff who work pursuant to a contract between the licensee and an employment agency in accordance with section 2(1)(c) of the Act were provided information on the Resident's Bill of Rights, policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports, whistleblowing protection, fire prevention and safety, emergency and evacuation procedures and infection control before providing their services in accordance with section 79(2) of the Act.[s.222(2)]

A review of the home's staffing schedules and monthly quality indicator records confirmed that the home used 20 hours of agency PSWs in April 2015, seven hours in May 2015, and 38.5 hours in June 2015, as well as 216 hours of agency registered staff in April 2015, 150.25 hours in May 2015, and 156.5 hours in June 2015.
i. The home's policy “Orientation” [policy identifier: V4-240, revised April 2012] stated that agency staff shall receive four hours orientation prior to providing care within the home. Agency staff would also receive a one page reference sheet outlining key information at that particular home.
i. Interview with an agency PSW working on the day shift during the inspection confirmed that an orientation checklist or one page reference sheet was not provided to them prior to starting work in the home and that there was no formal orientation given.
ii. A complaint received from a staff member during the inspection indicated that agency staff were not trained on the home's policies and procedures.
iii. Interview with the ADOC confirmed that the home did not currently have a formal orientation or training program for agency staff, and that four hours of orientation as noted in the policy was not provided. The ADOC also confirmed that they do not provide the agency staff information related to the Resident's Bill of Rights, policy to promote zero tolerance for abuse, duty to make mandatory reports, whistle-blowing protection, fire prevention and safety, emergency evacuation procedures and infection prevention and control prior to providing service in the home. (586)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 01, 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.

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
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

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 21st day of July, 2015**

**Signature of Inspector / Signature de l'inspecteur :**

**Name of Inspector / Nom de l'inspecteur :** Jessica Paladino

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