Ontario

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 14, 2015	2015_440210_0002	T-2419-15	Critical Incident System

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 - ELLESMERE
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 7 and 8, 2015.

During the course of the inspection, the inspector(s) spoke with registered nurse (RN), registered practical nurse (RPN), personal support workers (PSWs), physiotherapist (PT), director of care (DOC), assistant director of care (ADOC), maintenance staff, coroner, reviewed clinical records, policies and bed system evaluation record.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition
Minimizing of Restraining
Pain
Personal Support Services

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following right of resident #1 was fully respected and promoted: every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

Interview with RN staff #101 revealed the resident was using an electric bed, which was elevated at the head by a hand held controller. This device was used by the resident and staff, since admission several years ago. The resident was able to use the hand held controller to elevate the bed at the head, sit and play on the computer, watch TV or have a meal. The electric bed controller stopped working on an identified day in 2015, and it was not fixed untill five days later. Registered nursing staff #1 indicated because the resident was not able to elevate the head and perform his/her everyday routines independently after the bed controller stopped working, he/she was transferred into his/her wheelchair during the day.

Interview with registered nursing staff #101 confirmed that resident #1's right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible was not fully respected and promoted during the identified period. [s. 3. (1) 12.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

Interview with RPN staff #102 indicated the call bell was usually attached either on the bed sheets or resident's clothes on a specified side of his/her body.

Review of the progress notes for resident #1 indicated the resident had a full range of motion in one of his/her arms however it did not indicate which side of the resident the call bell should be attached to, in order to be easily accessible for the resident.

A record review of the critical incident report indicated on an identified date in 2015 the resident was found in a specified physical state.

Interview with an identified family member of resident #1 revealed that after the incident it was noted that the call bell was pinned to the left side of the resident's pillow. Review of the home's investigation notes confirmed that the call bell was attached to the left side of the resident head, to the mattress.

Interview with a staff member #103 who found the resident revealed that the call bell was attached to an accessible location of the resident.

Interviews with identified staff members #102 and #103 revealed contrary information about the accessibility of the call bell for the resident, and where the call bell should be placed to enable the resident to access it and confirmed that the assessments are not integrated, consistent with and complement each other. [s. 6. (4) (a)]

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 the resident so that their assessments are integrated, consistent with and complement each other, staff and others who provide direct care to a resident kept aware of the contents of the plan of care and given convenient and immediate access to it, to be implemented voluntarily.

WN #3: 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 the policy for bed rails is complied with.

Review of the home's policy "Bed rails", VII-E-10.20, dated January 2015, stated "bed rails may be used to manage the potential risk of injury in bed when the action or mobility of the resident is involuntary or unpredictable, or the use of bed rails enables the resident greater mobility, repositioning, or freedom of movement while in bed. The safety of residents in beds with raised rails and pads will be assessed and monitored. Bed rails will not be used for restraint of a resident. The RN/RPN will assess the resident's need for the use of bed rails, and entrapment risk, document on the resident care plan the resident's need for bed rails, including the number of rails to be raised. RN/RPN will collaborate with care team to manage levels of restlessness. The PSW will monitor residents with raised bed rails for comfort, security, adequacy of positioning, need for toileting and safety on an hourly basis".

Interview with an identified staff #103 revealed on an identified date, resident #1 was checked at specified times every 2 hours.

Interview with the DOC revealed that according to the above mentioned "Bed Rail" policy, the residents should be checked every hour for safety.

Interview with an identified staff #103 and review of the home's investigation notes confirmed that on an identified date in 2015, resident #1 had the right side rail up and was not checked every hour according to the policy. [s. 8. (1) (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 the policy for bed rails is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident beds are capable of being elevated at the head.

Reviews of the progress notes and the maintenance record indicated resident #1's bed was not capable of being elevated at the head for an identified time period.

Interview with RN staff #1 revealed the resident was using an electric bed, and was able to manage the electric bed, including elevating the head of the bed, by a hand held controller. This device was used by the resident and staff, since his/her admission several years ago. The resident was able to use the hand held controller with one of his/her hands or would ask staff to assist him/her.

Review of the progress notes indicated on an identified date in 2015, the electric bed controller stopped working and the bed was not capable of being elevated at the head. The electric bed had not been fixed or replaced with a manually controlled bed while resident #1 was using the bed up until five days later.

Review of the critical incident system report submitted by the home, indicated that on an identified date in 2015, the resident was found in a specified physical state.

Interview with the PT revealed the resident was at high risk for falls because of his/her diagnoses. Review of the PT assessment, indicated the resident was able to pull and push him/herself with assistance of the bed rail using one of his/her upper extremity to position him/herself in bed.

Review of the progress notes and maintenance record and interviews with PSW #103 and #104, RN #1, ADOC and maintenance staff #105 confirmed that resident #1's bed was not capable of being elevated at the head, either electronically or manually, for a period of five days until the date of the incident and then another eight days after the incident. [s. 12. (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 resident beds are capable of being elevated at the head, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Interviews with RN staff #1 revealed resident #1 used an electric bed with an air mattress and two quarter side rails located in the middle of both sides of the bed. The staff further confirmed that there was no assessment preformed or documented for the use of the side rails.

Interview with an identified PSW #103 revealed that he/she was not able to explain if the resident should have one or both side rails raised. Interview with another PSW #104 indicated resident #1 had the right side rail up and the left one down.

Interview with the ADOC indicated all residents with air mattresses should have both side rails up for safety and the expectation is the use of side rails should be documented in the resident written plan of care.

Review of the home’s policy titled "Bed Rails", VII-E-10.20, dated January 2015, stated "bed rails may be used to manage the potential risk of injury in bed when the action or mobility of the resident is involuntary or unpredictable, or the use of bed rails enables the resident greater mobility, repositioning, or freedom of movement while in bed. The safety of residents in beds with raised rails and pads will be assessed and monitored. Bed rails will not be used for restraint of a resident. The RN/RPN will assess the resident’s need for the use of bed rails and entrapment risk; document on the resident care plan the resident's need for bed rails, including the number of rails to be raised; collaborate with care team to manage levels of restlessness. The PSW will monitor residents with raised bed rails for comfort, security, adequacy of positioning, need for toileting and safety on an hourly basis".

Review of the progress notes and critical incident system report indicated on an identified date in 2015, in the morning, resident #1 was found in a specified physical state. Review of the home’s investigation records revealed a picture drawn by RN staff #106 who found the resident at the time of the incident. According to RN staff #106's description the bed was in a flat position. Review of the internal investigation record indicated the resident was not entrapped in the rails or the bed system.

Review of the PT staff assessment record from an identified date, indicated the resident was able to pull and push him/herself with assist of the bed rail with his/her right upper extremity to position him/herself in bed. Interview with PT staff revealed the resident was able (or had strength) to sit up by holding and pulling up onto the right side rail, but he/she was at risk for falls because of his/her diagnoses. Further, the PT confirmed that he/she did not conduct an assessment related to the use of bed rails.

Review of the home's record for bed system evaluation, dated August 7, 2013, revealed that bed 217-A used by resident #1 at the time of the incident was assessed for risks of entrapment. The audit revealed that resident #1's bed passed all zones of entrapment. There was no documentation to indicate if resident #1 has been assessed for appropriate use of bed rails and potential risks to the resident.

Review of the resident assessment instrument (RAI) minimal data set (MDS) assessment, from an identified date in 2015, the section related to bed rail use, and the

current written plan of care for resident #1, do not contain documentation related to bed rail use.

Review of the MOHLTC letter sent to all LTC homes on August 21, 2012, indicates residents that use one or more rails should be assessed using the guidelines established in the Health Canada Companion guide titled "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", 2003.

Interview with RN staff #101 indicated there is no specific resident assessment that is performed for the use of bed rails, including the size or location of bed rails according to resident needs. He/She explained that all electric beds have quarter side rails located at the middle of both bed sides, as received from the supplier. The electric beds are not altered with a different type of side rails or the original position of the side rails moved to a different location on the bed. Manually controlled beds come with full size bed rails that can be raised on one or both sides.

Review of the resident#1's clinical record (progress notes, assessment forms and the written plan of care)since his/her admission, and interview with identified registered nursing staff, ADOC, PT, and identified maintenance staff confirmed that the resident had not been assessed for the use of bed side rails according to the guidelines established in the Health Canada companion guide titled "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", 2003. [s. 15. (1) (a)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Review of the progress notes indicated the electric bed for resident #1 stopped working on an identified date in 2015, so that the bed could not be adjusted with the hand held controller. The controller no longer enabled the resident to control some of the electric functions including raising and lowering his/her head.

Review of the electronic maintenance request log presented by the maintenance staff #105 revealed that on an earlier identified date in 2015 a previous request was submitted for the same malfunctioning controller which was repaired three days later. Interview with maintenance staff #105 and RN staff #101 further confirmed that the resident had broken the controller on multiple occasions.

Review of the maintenance record and interview with RN staff #101 confirmed that on an identified date in 2015, a request for repair of the bed controller was sent to maintenance. Review of the communication record with the bed supplier company further revealed that three days later, the ADOC ordered the controller from the supplier. The supplier did not respond until seven days later, which was an order confirmation but not a scheduled date of repair. At the time of the resident's incident, the bed controller had not yet been repaired.

Interview with maintenance staff #105 revealed that there were no spare electric beds or controllers for electric beds in the home. According to maintenance staff #105 and RN staff #108, there was one empty bed with manual controls that was available in the home during the time period that resident #1's bed was deemed to be broken. Maintenance staff #105 confirmed that the spare bed was not offered to resident #1 to be used while his/her bed was non-functioning, because it was not communicated with the maintenance department as urgent.

Review of the home's maintenance records and interview with RN staff #101 and maintenance staff #105 confirmed the bed for resident #1 was not maintained in a safe condition or in a good state of repair. [s. 15. (2) (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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to pain is based on an interdisciplinary assessment with respect to the resident's health conditions including pain and other special needs.

Interview with RN staff #101 indicated resident #1 complained of pain and discomfort in certain parts of the body. The pain was usually resolved with turning, repositioning and straightening of the legs with staff assistance. The resident was using an electrical bed with a hand held controller that he/she was able to use with one of his/her hands to adjust the bed and put him/herself in a sited position.

Review of the pain assessments, from an identified date in 2014, indicated the resident had mild pain. A pain assessment from an identified date in 2015, indicated the resident had moderate pain.

Review of the written plan of care for resident #1 revealed there was no documentation related to pain or interventions were in place to manage the resident pain.

Review of the clinical record and interview with the registered nursing staff and ADOC confirmed that the written plan of care was not based on interdisciplinary assessment of the resident's identified pain and interventions were not indicated to manage the resident's pain. [s. 26. (3) 10.]

2. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Interviews with RN staff #101 and PSW staff #103 revealed that the resident #1's usual sleep pattern was to have breakfast in bed, lunch in the dining room using his/her wheelchair. The resident was then transferred back to bed after lunch time. Sometimes, if he/she was unable to sleep early in the morning, he/she was found by staff watching TV or playing on hi/her computer in bed. The staff indicated that the resident preferred to stay in bed most of the time because it was more comfortable than being in the wheelchair.

Review of the written plan of care revealed there was no documentation of resident #1 for the usual sleep pattern and preferences of resident #1.

Interview with RN staff #101 and review of the written plan of care confirmed that the resident #1's plan of care is not based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

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 plan of care related to pain is based on an interdisciplinary assessment with respect to the resident's health conditions including pain and other special needs, the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #8: 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 has 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 are documented.

Interview with RN staff #101 revealed resident #1 used an electric bed since admission several years ago however review of the clinical record revealed no documentation for an assessment related to the use of electric bed. The staff indicated that in the decision process if a resident needs electric bed the PSWs, registered nursing staff, and management staff are involved. The staff was not sure what exact factors are considered in determining the appropriateness of resident use of electric bed but he/she stated that it is probably the ability of the resident to use the controller (to control elevation of the head of the bed) or the family/resident's requests.

Interview with RN staff #101 revealed that the home has two types of beds; manual and electric and of the 32 beds on the unit approximately four to six beds are electric. The staff was not able to give exact number of electric beds on the unit nor was able to refer to documentation to find the information. With the electric beds, the level of the head of the bed can be adjusted by a hand held controller to position the resident. The staff confirmed the electric controller stopped working on an identified date in 2015, and it had not been repaired for twelve days, up to the date of inspection.

Review of the clinical record and interview with RN staff #101 confirmed that an assessment for resident #1 to use an electric bed was not documented.

2. Interview with RN staff #101 revealed a rationale for the use of an air mattress for resident #1 to prevent skin problems. Interview with the ADOC indicated the use of an air mattress should be documented in the resident's written plan of care.

Review of the clinical record and interview with the ADOC confirmed that the use of an air mattress by resident #1 was not documented in his written plan of care. [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.

Issued on this 20th day of August, 2015

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

Original report signed by the inspector.