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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2013	2013_195166_0034	002383,002433,000042,000266	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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 24, 25 and 26, 2013

Five critical incidents were inspected with this inspection,Logs# O-002383-12, 002433-12, 000042-13, 000266-13 and 000424-12.

During the course of the inspection, the inspector(s) spoke with Residents, the Director of Care, Registered staff, Personal Support staff, the RAI co-ordinator and the Social Worker.

During the course of the inspection, the inspector(s) reviewed residents' clinical health records, the licensee's policies related to zero tolerance of abuse and neglect of residents, responsive behaviours and records of staff education and training.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Log O-000424-13 and Log O-000042-13
There is no evidence that the results of the the licensee's investigation into the alleged staff to resident abuse incidents were reported to the Director. [s. 23. (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 the licensee shall ensure that the results of every investigation undertaken by the licensee shall be reported to the Director., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Log O-000424-13
The licensee failed to notify the Director immediately of an allegation of abuse of a resident.

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 the licensee shall ensure a person who has reasonable grounds to suspect abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Log O-003283-13
The licensee failed to ensure that when a resident is reassessed and the plan of care is reviewed and revised that different approaches are considered in the revision of the plan of care.
Resident #1's written plan of care related to responsive behaviour directs staff to:
-minimize Resident #1's behaviour of taking and keeping small articles from around the home area
-provide resident with daily free newspaper whenever available to keep the resident's attention occupied and redirect the resident's focus when necessary.
-when conflict arise, remove resident to a calm safe environment and allow resident to share/vent feelings
-while resident is up ,check the resident's hands or wheelchair every 30 minutes to 1 hour for possession of any edible objects that can be swallowed or ingested.

Resident#1"s RAI MDS RAPS behaviourial/wandering assessment indicates:
- the resident exhibits behaviours such as hoarding and wandering.
- the resident screams when staff approach .
- continue use of hourly check list and use of wrist alarm to monitor wandering.
-Resident participates in group and independent activities.Resident has a poor memory and has no recall.
-Resident can be" stubborn", but can easily be persuaded with the correct tone of voice.
-Resident "prefers to go around and take small articles off the staff cart" will refuse to return when asked, during such times the resident can very difficult to persuade.
-Resident has impaired cognition and wandering behaviour "which can cause falls". The resident self transfers and has an unsteady gait. Staff monitor on an hourly checklist.
Resident #1's RAI MDS was completed and the resident's plan of care does not reflect the alternative approaches to care identified in the assessment. [s. 6. (11) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. log O-00424-13
The licensee failed to notify the residents' substitute decision makers within 12 hours upon becoming aware of an alleged incident of abuse of a resident. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. log O-000424-13.
The licensee failed to ensure that the appropriate police force was immediately notified of any alleged,suspected incidents of resident abuse. [s. 98.]

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Issued on this 1st day of October, 2013

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