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

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
Feb 5, 2015	2014_306510_0024	T-000057-14	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 - ETOBICOKE
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

IRENE PASEL (510), KATHLEEN MILLAR (527), MELODY GRAY (123)

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): October 14, 15, 16, 17, 20, 21, 22, 23, and 24, 2014.

Included in this Resident Quality Inspection were complaints #T-000244-14 and T-000487-13 as well as critical incident #'s T-000384-13, T-000396-13, T-000468-13, T-000586-14, T-000872-14, T-000917-14, and T-000984-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Director of Resident Programs and Admissions, Resident Relations Coordinator, Environmental Manager, Director of Dietary Services, registered staff, personal support workers (PSW) and housekeeping staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
Training and Orientation

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

8 WN(s)
5 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 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 did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy #V3-010 titled 'Abuse and Neglect Resident', directed that if any employee has any knowledge of an incident that constitutes resident abuse or neglect, the employee must immediately inform the Director of Administration (DOA) and/or charge nurse in the home and "immediately report the following to the (MOHLTC) Director". Included in the list following is "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". On an identified date the home received a report that an identified resident had been pushed by a staff member on an identified date and that the staff then gathered around the resident laughing. The Director of Care (DOC) confirmed that this allegation was received by the home and was investigated by the home. The DOC confirmed a Critical Incident was not submitted to the Ministry of Health and Long Term Care as required by the home's policy. The home's policy was not complied with. [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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #2: 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 did not ensure that the home, furnishings and equipment were kept clean and sanitary.

On an identified date in 2014, the burgundy and green coloured chairs in an identified area were observed to be stained and soiled. On the same dates, the orange and red high back chairs observed in identified resident rooms were stained and soiled. The privacy curtains in identified rooms were soiled and stained. The window curtains in identified rooms had yellow stains approximately four inches up the curtain and the hems on the curtains were ripped. The home's policy # V8-200, titled Housekeeping - Cleaning and Sanitizing Protocols, directed that audits of the building contents would be conducted to ensure cleanliness and respond appropriately when deficiencies were identified. The housekeeping staff, nursing staff and the Environmental Manager confirmed the furnishings and curtains were not clean. [s. 15. (2) (a)]

2. The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On identified dates in 2014 it was observed that the table top surface in an identified area had varnish peeling off. On the same dates, the chairs in another identified area were observed to have varnish worn off the arm rests and legs of the chairs. In addition, the high and low back chairs in identified resident rooms had varnish worn off. In one identified room, the bathroom vanity was chipped, and the bedside tables in other identified rooms were chipped with ragged edges. The linoleum baseboard was missing under the radiator and was found rolled up under the bathroom counter in one room. The home's policy # V8-360 titled Preventative Maintenance Systems, directed that there would be routine and preventative maintenance schedules for resident care equipment to ensure that equipment is maintained in a good state of repair. The nursing and housekeeping staff, and the Environmental Manager confirmed the furnishings were not maintained in good 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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) The home's internal investigation records and the records of identified residents were reviewed and information indicated that they were involved in a physical altercation which resulted in the injury of one identified resident.

The DOC and ADOC were interviewed and confirmed that the incident occurred which resulted in the injury.

B) The home's internal investigation records were reviewed including the critical incident report. The records of identified residents were reviewed and information indicated that on an identified date staff members witnessed an identified resident touching other identified residents inappropriately.

The DOC and the ADOC were interviewed and confirmed that two identified residents were abused by an identified resident.

C) The home's records including internal investigation record and the record of an identified resident were reviewed and it was noted the identified resident was neglected by a staff member who did not change the resident's continence product for a period of time after the resident made the request.

The DOC and the ADOC were interviewed and they confirmed that the resident was neglected by the staff member and also reported that the home took action as per the home's policies and procedures. [s. 19. (1)]

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 residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

On an identified date, the home received an allegation of: 1) staff to resident abuse involving an identified resident and 2) lack of protocol after a resident fall. This was investigated immediately, by the ADOC who interviewed staff involved in the incident. The investigation determined that no abuse occurred and staff followed post fall protocol. An interview on an identified date, with the staff member assigned to the identified resident on the day in question revealed the resident fell after unexpectedly and suddenly pulling away from the staff that was supporting them. As well, staff described a process for assessment of the resident post fall that was consistent with policy.
On an identified date, the ADOC confirmed the above and confirmed that the complainant had not been advised of the results of the investigation or why administration believed the allegations were unfounded. [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the training and orientation program was evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

The Mandatory Educational Package, 2014, prepared by an identified service, was reviewed in addition to the hand out new staff received at the orientation. A Leisureworld Orientation Evaluation form was included in the new staff hand out. The DOC and ADOC were interviewed and stated these evaluations were sent to corporate office. An annual evaluation, dated December 2013, was reviewed. The document stated that the management team evaluated the process of completing mandatory education for all front line staff. The DOC confirmed that front line staff did not contribute to the evaluation and that the staff evaluations were neither reviewed or considered. The training and orientation program was not evaluated in accordance with evidence based practices. [s. 216. (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 the training and orientation program was evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: 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:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's right to designate a person to receive information concerning any transfer of the resident and to have that person receive that information immediately, was respected.

An identified resident who demonstrated responsive behaviors, was seen by Behavioral Supports Ontario. The resident demonstrated aggressive behaviors to staff and residents.
On an identified date, the resident was relocated from their room to a room on a secure home area. It was reported that the resident was transferred and the Power of Attorney (POA) was not informed. The DOC confirmed that the POA was not informed prior to the move of the identified resident to a secure home area. [s. 3. (1) 16.]

WN #7: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure that the provision of the care set out in the plan of care was documented.

A) The plan of care for an identified resident identified that skin assessments were to be completed on bath days, the resident was to be repositioned at least every two hours, and have safety checks hourly. The PSW's and registered staff confirmed that the PSW's were expected to document the interventions in Point of Care (POC) as identified in the plan of care. Review of the POC documentation by the PSWs revealed that the repositioning of the resident at least every two hours, the hourly safety checks, and the skin assessments on bath days were inconsistently documented for several identified months.

B) An identified resident returned from the hospital on an identified date with a new diagnosis.
The home's "Resident Re-Admission Checklist for Registered Nursing Staff", form number V3-050, revised April 2013, directed that residents should have a head-to-toe skin assessment, pain assessment and restraint assessment on Day 1 of a resident's re-admission.
The registered staff confirmed that the head-to-toe assessment, pain assessment, and restraint assessment for the identified resident was performed on day one of their re-admission from hospital. They also confirmed the assessments should have been documented on the skin assessment tool, the pain assessment tool and the restraint tool in Point Click Care (PCC) on the date the resident was re-admitted to the home. The registered staff, the DOC and the ADOC confirmed that the care provided was not documented as per the home's Re-admission Checklist and as per legislative requirements. [s. 6. (9) 1.]

WN #8: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident and the resident's substitute decision-maker, if any, was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

On an identified date, the home received an allegation of staff to resident abuse involving an identified resident. This was investigated immediately, by the ADOC who interviewed staff involved in the incident. The investigation determined that no abuse occurred.
On an identified date it was reported that the substitute decision maker for the identified resident had not been informed of the results of the investigation. In an interview with the ADOC, she confirmed the substitute decision maker had not been notified of the results of the investigation. [s. 97. (2)]

Issued on this 11th day of February, 2015

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

Original report signed by the inspector.