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Performance Improvement and Compliance Branch

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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
Jun 29, 2015	2015_378116_0007	T-1693-15	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 - ETOBICOKE
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

SARAN DANIEL-DODD (116), JOELLE TAILLEFER (211), NICOLE RANGER (189), SHIHANA RUMZI (604)

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): April 29, 30, May 1, 4, 5, 6, 7, 8, 11, 2015.

The following critical incident inspections were conducted concurrently with this Resident Quality Inspection (RQI): T-2265-15 & T-2229-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Associate Director(s) of Care (ADOC), resident assessment instrument(RAI) coordinator, director of resident programs and admissions, maintenance manager, director of dietary/support services, registered dietitian, housekeeping supervisor, physiotherapist, behavioural support services coordinator, activation aides, dietary aide, Resident Council President, Family Council President, registered staff, personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

9 WN(s)
4 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a specified date, the licensee submitted a critical incident report to the Director reporting that, an identified PSW attempted to provide a shower for resident #020. During the shower, it was identified that the resident was sliding from the shower chair and in order to prevent the resident from falling, three staff members used a standing lift instead

of the Hoyer lift which is directed in the resident's plan of care. After the shower, the identified PSW brought the resident into an identified dining room with a hospital gown and a towel on the resident's lap.

Interviews held with an identified PSW, registered staff, DOC and resident #020 confirmed that the allegations were founded and that the resident was dressed inappropriately and placed in the dining room which constituted a lack of courtesy and respect under the Resident's Bill of Rights. The PSW was disciplined and provided with retraining on the licensee's non-abuse and Resident's Bill of Rights policy. [s. 3. (1) 1.]

2. During an interview with an identified resident, it was reported to the inspector that an identified staff member does not provide toileting when requested by the resident. The identified staff member informs the resident that he/she needs to wait as it is not his/her scheduled toileting time. The identified resident stated that this makes him/her feel that the care is not individualized to meet his/her toileting needs and the staff member is not treating him/her with dignity.

Interviews with registered staff and PSWs confirmed that there was an incident in the past where the resident reported to the registered staff that he/she was not toileted as per his/her request. An interview held with the DOC confirmed that residents are to be toileted to meet the resident's needs. [s. 3. (1) 1.]

3. On an identified date, the licensee submitted a CIS to the Director reporting that an identified PSW went inside resident #020's room to provide care. Resident #020 was sitting in his/her chair watching television, when the identified PSW approached the resident and immediately pulled his/her shirt in attempts to remove the shirt without informing or asking permission to do so.

An interview with resident #020 revealed that the identified PSW entered the resident's room without permission or introducing himself/herself and did not enquire if the resident was ready to go to bed at that time. An interview held with the identified PSW confirmed that he/she did enter the room without permission or introduction to the resident. Interview with the registered staff and DOC confirmed that the allegations were founded and that the PSW's behaviour was inappropriate and constituted a lack of courtesy and respect under the Resident's Bill of Rights. [s. 3. (1) 1.]

4. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information

Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date, the inspector observed an unattended medication cart to be stored outside of an identified dining room during lunch on an identified unit. The Electronic Medication Administration Record (E-MAR) screen was left open to resident #012's personal medication administration record which was visible to the public.

On a separate occasion, the inspector observed during the medication pass on an identified unit that the E-MAR screen was left open and unattended to resident #047's personal medication administration record. A registered staff member arrived shortly and confirmed the E-MAR screen was left open and revealed an identified residents medication profile.

The identified registered staff members confirmed that the medication screen was unlocked and visible to anyone passing by and did not protect the resident's personal health information.

An interview held with the Associate Director of Care (ADOC) confirmed that the medication cart and E-MAR screen is to be kept locked at all times when the cart is left unattended. [s. 3. (1) 11. iv.]

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 following resident rights are fully respected and promoted:

-every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and,
- have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On an identified date, the inspector observed that the right bed rail was engaged in the up position for resident #009. An interview with resident #009 revealed that he/she wants the right bed rail engaged for mobility.

Record review of the written plan of care did not indicate the resident's preference for the use of bed rails.

An interview with an identified registered staff member and an ADOC confirmed that the resident's written plan of care did not include the use of bed rails and did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, the licensee submitted a CIS to the Director reporting that on an identified date, an identified PSW attempted to provide a shower for resident #020. During the shower, it was identified that the resident was sliding from the shower chair and in order to prevent the resident from falling, three staff members used a standing lift instead of the Hoyer lift which is directed in the resident’s plan of care. After the shower, the identified PSW brought the resident into the dining room with a hospital gown and a towel on the resident's lap.

Record review and interviews with the identified PSW, registered staff, and DOC confirmed that an inappropriate lift was used during the transfer. The PSW and registered staff were disciplined and provided with retraining on the licensee’s lifts and transfer policy. [s. 6. (7)]

3. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

The written plan of care for resident #001 indicates that he/she requires extensive assistance of two persons for transfers and bed mobility. Record review of the minimum data set (MDS) quarterly assessment conducted on a specified date, documents that resident #001 experienced a significant change in status regarding physical functioning and was coded as being bed fast. The inspector observed the resident throughout the inspection and was noted to be seated in a wheelchair.

An interview with a registered staff member revealed that the resident was isolated over a specified one month period due to experiencing contagious symptoms during an identified outbreak in the home. An interview held with the DOC and the resident assessment instrument (RAI) coordinator confirmed that residents' plan of care was not revised when the resident's care needs 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
- ensure that the care set out in the plan of care is provided to the resident as specified in the plan and,
- 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #006 was seen on an identified date for an external specialist consultation. Upon return from the consultation, the consulting physician prescribed two identified medications to be administered twice per day for a four week period and to repeat x1 for the treatment.

Review of the external consultation report indicated that resident #006 was followed up in the specialist clinic and it appeared on his/her medication administration record (MAR) that the repeated prescription was not refilled and the resident did not receive the identified medications as previously prescribed.

Review of the medication administration record confirmed that the medication was administered over a four week duration over a specified period, rather than eight weeks as indicated in the original consulting order.

An interview with an identified registered staff member and the DOC confirmed that the order was transcribed incorrectly and resident #006 did not receive the medication as prescribed. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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 participate in the implementation of the infection prevention and control program.

On an identified date, the inspector observed that resident #009’s door had a posted droplet isolation precaution sign. On the same day, the inspector observed an identified PSW enter the isolation room without the personal protective equipment (PPE).

An interview with the identified PSW and the ADOC confirmed that resident is isolated for an identified infection and the PPE’s should be donned before entering the resident’s room. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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 is complied with.

On an identified date, the inspector conducted an inspection of the medication cart on an identified unit.
During the review of the narcotic/medication count sheet it was observed that there was a discrepancy for six residents. The narcotic count and narcotic sheet did not match for two scheduled medication passes for the following six residents:

- resident #043- The narcotic count sheet indicated six tablets remaining for an identified controlled substance and the narcotic count was five tablets.

- resident #044 - The narcotic count sheet indicated 12 tablets remaining for an identified controlled substance and the narcotic count was 10 tablets.

- resident #045 - The narcotic count sheet indicated 4.5 tablets remaining for an identified controlled substance and the narcotic count was four tablets.
- resident #014 - The narcotic count sheet indicated nine tablets remaining for an identified controlled substance and the narcotic count was seven tablets.
- resident #046 - The narcotic count sheet indicated nine tablets remaining for an identified controlled substance and the narcotic count was seven tablets.
- resident #047 - The narcotic count sheet indicated six tablets remaining for an identified controlled substance and the narcotic count was five tablets.

The licensee’s policy entitled "Medication Management-Controlled and Narcotic Medications" Number: V3-920 states that at the time of administration of a control or narcotic medication, the nurse is to complete the documentation on the control and narcotics records at the time the medication is removed from the container. Following the administration of the medication, the nurse completes the documentation on the resident's Medication Administration Record.

An identified RPN confirmed that he/she did not sign the narcotic and controlled drug administration records for the two identified medication pass schedules for the identified six residents.
The DOC and ADOC reviewed and confirmed that the narcotic and controlled drug administration records for the identified six residents’ did not match the narcotic count. [s. 8. (1)]

2. During interviews held with resident #006 and interview with resident #011’s family member revealed that their resident rooms are too warm.

Review of the home policy entitled "Hot Weather and Heat Contingency Protocols" #V3-700 indicated that maintenance is responsible to record indoor temperature, humidity percentage from various locations within the buildings, between 11 a.m. and 3 p.m. daily and document the temperature on the electronic computerized maintenance system or air temperature log and in the Administrator's report.

An interview held with the maintenance manager indicated that the thermostat and the air temperature of each resident's room are verified each morning and then randomly during the afternoon. Interviews held with the director of support services and the maintenance manager confirmed that the home temperature was not documented and the home policy was not complied with. [s. 8. (1) (b)]

3. During an interview with resident #016 on an identified date, the resident reported that he/she is missing two pairs of socks and a pair of pants since four months ago. The resident stated that he/she reported the missing items to staff on the unit and to the housekeeping staff.

A review of the home's policy entitled "Lost/Missing Clothing", V8-300, revised April 2012, revealed that all reports of missing clothing/items by residents and family members will be reported on the lost/missing items form and will be provided to the Nursing staff in the resident home area to begin a search for missing items/clothing.

An interview with an identified PSW and housekeeping staff revealed that a search was conducted but the missing items were not found. An interview with the Director of Support Services, registered staff, and review of the homes housekeeping and laundry missing items binder confirmed that a lost/missing items form for resident #016 could not be located. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

On three separate occasions over the course of the inspection, the inspector observed a bed alarm for resident #014 to be frayed and exposing yellow and green wires.

A review of the manufacturer’s instructions for the bed alarm directs the staff to visually inspect the sensor pad and monitor for physical damage. If damage is noted, remove it from service.

The inspector brought the condition of the bed alarm to the attention of a registered staff member who confirmed that the bed alarm was not safe for use and replaced it with a new bed alarm.

Further interviews held with a PSW and the ADOC confirmed the bed alarm condition was not safe for use by residents and the home did not follow the manufacturer’s directions. [s. 23.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The written plan of care for resident #001 indicates that the resident receives a shower on established days.

An interview with the resident revealed that he/she currently receives a shower however, his/her preferred method of bathing would be to have a tub bath and a shower on alternate days.

Interviews held with registered staff members and PSWs confirmed that the resident receives a shower and the resident's preference for bathing is identified upon admission and should be documented on the resident's plan of care.

An interview with the DOC confirmed that the residents should receive a bath by the method of his or her choice. The DOC indicated that a review of bathing preferences will be conducted to ensure that all resident's preferred bathing method is updated and reflected accurately in the written plans of care. [s. 33. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, during the lunch meal service on an identified unit, the inspector observed resident #048 sliding down in his/her wheelchair and was not repositioned over a specified period.

An interview with an identified PSW confirmed the resident required repositioning and proceeded to reposition the resident with the assistance of another PSW. [s. 73. (1) 10.]

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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(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).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for 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: supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On two separate occasions, the inspector observed in resident #015's room, a floor/fall mat which had an offensive odour and was soiled with brown splatters. The floor mat remained in the same condition throughout both days.

An interview held with an identified housekeeping staff and the housekeeping supervisor indicated there was no confirmed department assigned to clean the floor/fall mat.

An interview with the housekeeping supervisor and an identified PSW confirmed the offensive odour and soiled state of the floor/fall mat. The floor mat was immediately removed from the room and cleaned and disinfected upon bringing it to the attention of the housekeeping manager who further confirmed that the floor mat was not kept in good condition.

The housekeeping manager indicated that a review of procedures for cleaning and disinfection of the floor mats will be conducted to ensure that the responsibility will be assigned to a specific department and/or responsible person(s). [s. 87. (2)]

Issued on this 7th day of July, 2015

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

Original report signed by the inspector.