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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2015	2014_297558_0020	T-060-14	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 - NORFINCH
22 NORFINCH DRIVE NORTH YORK ON M3N 1X1

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

BARBARA PARISOTTO (558), NATASHA JONES (591), TIINA TRALMAN (162)

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): November 21, 24, 25, 26, 27, 28, December 1, 2, 3, 4, 2014.

The following complaint logs were inspected: T-316-14, T-484-13, T-578-13.
The following Critical incident logs were inspected: T-296-13, T-517-14, T-1464-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant director of care (ADOC), evening nurse manager, program manager (PM), environmental services manager (ESM), food service manager (FSM), registered dietitian (RD), physiotherapist (PT), resident relations coordinator (RRC), registered staff, personal service workers (PSW), housekeeping staff, activation aides (AA), families and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
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
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours

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

12 WN(s)
1 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. 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 has failed to ensure that residents are protected from abuse by anyone.

Resident #47 has a diagnosis of Alzheimer's disease with a history of agitation and pacing. The MDS assessment dated May 9, 2013, identified the resident as resistive to care and that mood persistence is easily altered. Since 2011, the resident is monitored monthly by a geriatric psychiatrist and weekly by the attending physician.

A critical incident report was submitted on June 20, 2013, related to an alleged incident of abuse. A record review and staff interview indicated that resident #47 was receiving morning care, became agitated and hit the PSW providing care. The PSW confirmed throwing a plastic cup to the resident while exiting the resident's room. The resident sustained a laceration to the upper left cheek.

A review of the home's investigation concluded that the PSW's delivery of care was inappropriate and perceived as abusive. The PSW was disciplined and was later re-assigned to another home area. [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 are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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:
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident has been able to pursue social, cultural, religious, spiritual and other interests, develop his or her potential and has been given reasonable assistance by the licensee to pursue these interests and develop his or her potential.

Observations of resident #15 during the course of the RQI revealed that he/she did not receive reasonable assistance to participate in activities geared to his condition.

Record review of the document titled multi-day participation report for the month of November 2014, and the document titled one-to-one schedule of visits for the month of November 2014, revealed that the resident was not assisted to participate in activities as outlined in the plan of care.

An interview with resident #15's spouse revealed that he/she was not assisted to participate in activities during the month of November 2014.

Interviews with the AA, registered staff and PM, confirmed that resident #15 did not receive assistance to participate in activities as outlined in his/her care plan. [s. 3. (1) 23.]

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. (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).

Findings/Faits saillants :

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

Observations of resident #15 during the course of the RQI revealed that he/she did not participate in activities as outlined in the care plan.

Record review of the document titled multi-day participation report for the month of November 2014, and the document titled one to one schedule of visits for the month of November 2014, revealed that the resident participated in one scheduled activity, and did not receive any one on one social visits as instructed in the care plan.

Interviews with the AA, registered staff and PM revealed that resident #15 did not receive one on one social visits as instructed in the care plan.

The AA and the PM confirmed that the care set out in the plan of care was not provided to the resident. [s. 6. (7)]

WN #4: 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.

A review of policy #V7-125 one-to-one scheduled programs revised April 2012 states:
- one-to-one visits will take place for those residents experiencing a decreased or low participation,
- residents are to receive visits on a scheduled basis,
- each resident and their family should be included and given opportunities to comment and provide suggestions related to the one-to-one visiting schedule, and
- change in participation levels of residents will be noted.

Interviews, record reviews and observations revealed that resident #15 experienced a deterioration in both cognitive and physical functioning, post hospitalization in October 2014. Upon reassessment of the resident's recreation needs the resident required one-to-one programming, a goal of 8 contacts or higher per month, as described by the PM. A review of one-to-one schedule of visits form and the multi-day participation report for November 2014, revealed that the resident did not receive the visits. An interview with resident #15's spouse revealed that he/she was not given the opportunity to comment and provide suggestions related to the one-to-one visiting schedule.

The AA and the PM confirmed that the home did not comply with the above-mentioned policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Record review of the policy #V3-1050 titled medication management – resident self-administration revised March 2012, revealed the policy did not include instructions to obtain a physician's order permitting the resident to keep medication that is being self-administered at the bedside on their person as required by the legislation.

Interview with the DOC confirmed that the policy does not include the legislative requirements related to medication self- administration. [s. 8. (1) (a)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with.

Record review of the policy #V3-1050 titled medication management – resident self-administration revised March 2012, revealed that the nurse and/or consultant pharmacist will perform a self-administration audit to assess the resident's ability to self-medicate, and also includes that, for the safety of others, medication must be kept in a locked container in the resident's room with only the resident and the registered nursing staff of the home area where the resident resides to have access to the locked container.

Interviews with identified registered staff, and with resident #16 revealed that the medication that the resident was permitted to self-administer was not kept locked in the resident's room. An interview with the DOC revealed that a self-administration audit to assess the resident's ability to self-medicate was not completed.

The DOC confirmed that the home did not comply with the medication policy. [s. 8. (1) (b)]

WN #5: 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 has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On November 25, 2014, the inspector observed a loose and shaky grab bar in the 2B bathing room shower stall and two loose and shaky grab bars in 3B bathing room shower stall.

Staff interviews revealed that they were not aware of the loose and shaky grab bars.

A review of the home's referral system for maintenance issues revealed that there was no reporting of the identified loose grab bars.

An interview with the ESM revealed that he/she was unaware of the identified grab bars and confirmed he/she did not receive a maintenance requisition.

The inspector observed on November 28, 2014, and December 1, 2014, that the identified shower stall grab bars were secured. [s. 15. (2) (c)]

WN #6: 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. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A record review indicated on June 20, 2013, a critical incident related to an alleged abuse was submitted to the Director. An interview with the DOC and ED confirmed the results of the investigation were not reported to the Director. [s. 23. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents' Council received a written response within 10 days of receiving concerns or recommendations from the Residents' Council.

A review of the Residents' Council minutes revealed that the licensee failed to respond in writing to the following concerns or recommendations identified at the August 17, 2014, Residents' Council meeting related to nail care, chapel maintenance concerns, volunteers assisting residents, and frequency of outings.

Interview with the PM confirmed that a written response was not provided to the Residents' Council. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Family Council received a written response within 10 days of receiving concerns or recommendations from Family Council.

The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations dated:

- January 9, 2014, related to internet access,
- January 30, 2014, salad dressings,
- February 28, 2014, placing cognitively well with cognitively impaired residents,
- March 7, 2014, staff and resident interaction,
- March 10, 2014, sodium free diets,
- date unknown - regarding frequency of serving potatoes,
- April 20, 2014, quality of food, paying for special holiday dinners, and
- August 2014, loud evening staff and toilet roll installation.

The ED could not confirm the date of response to each of the above-mentioned concerns. [s. 60. (2)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the Residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home's current satisfaction survey includes the use of the stage 1 questions from abaqis. Two additional questions measuring satisfaction using a scale from 1 to 10 were added.

An interview with the ED revealed that the abaqis quality management system is being used as the home's satisfaction survey and that it does not include questions related to satisfaction with services such as occupational therapy, physiotherapy, continence care, skin and wound program, and falls/restraints. [s. 85. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Record reviews and staff interviews revealed on January 23, 2014, resident #46 sustained a fall and fracture to the ankle, that resulted in a transfer to hospital. A critical incident was submitted to the Director on January 30, 2014.

An interview with the DOC confirmed that the Director was not informed within one business day after the occurrence of the incident. [s. 107. (3) 4.]

WN #11: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Record review of the physician's orders for three prescribed topical medications ordered for resident #16 did not include orders for self-administration of the medications.

Interview with resident #16 revealed that the resident had been self-administering the three above mentioned topical medications without orders for self-administration. Interviews with registered staff and the DOC confirmed that the physician's orders did not include instructions for self-administration of the medication. [s. 131. (5)]

2. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

On November 25, 2014, the inspector observed a prescription medication at resident #16's bedside. Record review of the doctor's order for this medication revealed that the physician had permitted the resident to self-administer, but the order did not permit the resident to keep the medication at the bedside.

An observation revealed and an interview with resident #16 identified that the above mentioned medication is kept unlocked in a pouch on the resident's rollator in the resident's room. Interviews with registered staff confirmed that the above mentioned medication is kept at the resident's bedside and that there was no physician's order permitting the medication to be kept at the resident's bedside.

An interview with the DOC confirmed that medication should not be kept at the resident's bedside without a physician's order. Corrective action was taken. [s. 131. (7)]

WN #12: 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 failed to ensure that staff participate in the implementation of the infection prevention and control program.

On November 21, 26, and 27, 2014, the tub/shower rooms throughout the home were observed to have unlabeled body wash/shampoo and body lotion bottles resting on shower grab bars. Commode hats were observed on the floor under sinks and next to garbage bins in the bathrooms located in the tub/shower room.

Staff interviews revealed the body wash/shampoo bottles are not labeled with the residents' name and that residents do not have an individual bottle for personal bathing use. A registered staff identified body lotion is to be labeled with the resident's name. Staff interviews revealed the commode hats are to be placed under shower chairs in the event a resident needs to void during bathing.

An interview with the DOC confirmed that body wash/shampoo and body lotion is to be labeled for individual personal use, and commode hats are to be stored with the commode and not on the floor. [s. 229. (4)]

Issued on this 15th day of January, 2015

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

Original report signed by the inspector.