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 8, 2014	2014_246196_0008	S-000131-14	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 - NORTH BAY
401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5

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

LAUREN TENHUNEN (196), JANET MCNABB (579), VALA MONESTIMEBELTER (580)

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): May 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 22, 23, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aids, Housekeeping staff members, Maintenance staff member, Environmental Service Manager (ESM), Registered Dietitian (RD), Residents and Family members.

During the course of the inspection, the inspector(s) conducted a daily walk-through of all resident home areas, observed the provision of care and services to residents, observed the staff to resident interactions, conducted interviews with residents and family members, reviewed the health care records for several residents, reviewed numerous home policies and procedures and observed the dining and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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).

Findings/Faits saillants :

1. During this inspection, Inspector #580 noted a lingering odour around resident #961. On May 15, 2014, Inspector #579 interviewed staff member #100 and asked what would be done when there is an odour noted from a resident. It was reported that air freshener sprays, plastic circle air fresheners are put under beds and housekeeping also can get a charcoal air freshener from maintenance to hang up. When asked how staff look after catheter care they stated that the leg bag is changed to a night bag and vice versa in the a.m. and that the bags are replaced once per week on bath and linen change day. This staff also stated that some staff "don't do their job" and don't rinse out the bags properly and when questioned about how staff know what routine to do for catheter care, it was reported that it is by "word of mouth" and that there was a note in the communication book recently of what to do as they were having concerns regarding the catheter.
On May 14th, 2014, Inspector #579 accessed the policies related to the home's continence program and there were several policies on products, suprapubic catheters and regular catheter insertion and removal.

The current care plan for resident #961 was reviewed and included a focus of "Bladder Incontinence r/t leakage from catheter" but it did not include direction about caring for the catheter and the catheter bags and peri care for odour.

The licensee 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. [s. 6. (1) (c)]

2. The current care plan for resident #963 included the focus of "bladder incontinence" and had the interventions of "Assist with pericare pc toileting. Wears an incontinent product at all times." The focus of "ADL Self Care Performance Deficit r/t poor gait and dementia" included the intervention of "TOILET USE: Requires assistance of 1 staff with peri care and hand hygiene pc toileting. Uses raised toilet seat; check that it is secure prior to use". The kardex as found online included the same information. The most recent MDS assessment dated February 17, 2014 identified resident #963 as requiring "extensive assistance of one person for toilet use, transfer, use of walker, deteriorated and frequently incontinent of bowel and bladder, use of pads or briefs". An interview was conducted with management staff member #101 on May 22, 2014 and it was confirmed to the inspector that the written plan of care did not provide clear directions to direct care staff regarding the continence care requirements of resident #963. Specifically the written plan of care did not include the type of product to be

used for incontinence, if the resident is to be toileted, whether the resident is incontinent of both bowel and bladder and if they are on a toileting schedule or scheduled times to be checked for incontinence in product.

The licensee 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. [s. 6. (1) (c)]

3. On May 14, 2014, staff member #102 told Inspector #580 that resident #944 uses the bed rail for reassurance and showed the Inspector the logo for the bed rail dated March 28, 2013 which indicated: bed rail x 1, may request 2.
On May 14, 2014, resident #944 told Inspector #580 that they do not remember having the second rail put up but likes to know that they can if they want to. On May 14, 2014, staff member #108 told Inspector #580 that resident #944 does have one rail in use and the PSW does not remember ever using the second rail. On May 14, 2014, staff member #104 told Inspector #580 that resident #944 had never asked for the second bedrail to be put up.
On May 15, 2014 Inspector #580 reviewed the following health care records for resident #944:
-the care plan dated March 25, 2013 which indicates the use of siderail x 1.
-the MDS assessment dated March 3, 2014 noted the use of a half rail on one side.
-the Resident Assessment Lift/Transfer Program dated May 29, 2013 stating one bedrail.

The bedrail logo in the resident #944's room conflicted with the health care records and the staff care directions and therefore did not set out clear directions to staff.

The Licensee 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. [s. 6. (1) (c)]

4. Inspector #196 observed the dining room service on one of the units on May 6, 2014 at 1720hrs and observed resident #888 at a particular table with a half slice of bread buttered with crusts in place. A review of the "dining serving report" was conducted by the Inspector and for this resident it noted "cut up intervention - No crusts". An interview was conducted with staff member #105 and it was confirmed that this resident was not to be served bread with crusts.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan [s. 6. (7)]

5. On May 21, 2014, at 1420hrs, resident #916 was observed lying in bed on their side, sleeping soundly. The bed was not in its lowest position as was confirmed by staff member #106. The current care plan relating to falls included the intervention of "ensure bed is in lowest position while (resident #916) is in it".

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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 that ensures that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan is provided to residents, 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. On May 23, 2014, during a walk through of resident care areas, several areas of disrepair were observed. In one resident room, the door to the washroom was chipped around the bottom edge, there was rust on the baseboard heater in the washroom, there were stains on the floor and the door edges had chipped paint. The

white cabinets in five of the resident washrooms had water stains. The doors to the washrooms in three resident rooms had chipped wood edges and chipped paint on the trim around the doors. The flooring behind the toilet in a resident washroom was stained, the dry wall was chipped along the wall surface and there was a piece of dry wall missing from behind the toilet where it meets the baseboard. In another resident washroom, there were drip stains along the wall below the washroom sink, there was chipped dry wall and stains on the floor around the base of the toilet.

An interview was conducted with the Environmental Services Manager (ESM) on May 22, 2014 and it was reported to the inspector that formica is usually put onto the washroom doors that have been chipped, that it is the wheelchairs that cause the damage to the doors on the resident washrooms, that water leaks on the white cabinets in the shared washrooms was possibly from toothbrushes put away wet and that they try to replace the cabinets as they can be done.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

2. During inspection, Inspector #580 observed a washroom on one of the units that had a wall portal with an opening and dry wall was in disrepair.
Inspector #196 observed the common TV room on one of the units and noted cracked paint on window sills, coffee table edges that were chipped, the seal was broken on the window and moisture had gathered between the window panes, the seat surface of a burgundy wing chair was soiled and the floor surface was soiled in multiple areas.

On May 13th, 2014 at 1145hrs Inspector #579 interviewed the Environmental Services Manager (ESM) who demonstrated the Ipod system and the maintenance programming as well as the audit process. According to the ESM, there was no scheduled program to replace windows or to paint around these areas and reported that the maintenance staff respond to the audit process and do paint touch ups in between painting.
The audit process is done monthly on different rooms throughout the home. One particular resident room had been audited in December 2013 and it was noted that the bathroom required repair between the sink and the toilet. The ESM reported that this repair would usually be done within the week or the month following the audit. At the time of inspection, which was several months after the audit, the area remained unchanged.
On May 13, 2014, Inspector #579 observed the common area on one of the units and

noted there were rust stains on top of the base board heater and small chips out of a small round table.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and 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 that ensures that 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 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On May 6, 2014, Inspector #196 noted a strong, lingering odour of urine and observed stains on the flooring around the base of the toilet in the shared washroom in a particular resident room. In addition, the shared washroom of two resident rooms was noted to have a strong, lingering odour of urine on May 22, 2014.
An interview was conducted with staff member #107 on May 21, 2014 regarding the urine odour in a resident room and it was reported that one resident urinates on the floor and despite letting the housekeeping staff know and being provided with a bucket and mop for use on the evening shifts to address any urine spills, the odour remains.
An interview was conducted with housekeeping staff member #108 on May 22, 2014 regarding urine odours in resident shared washrooms and it was reported that the washrooms are cleaned once per day and are not re-checked later in the day, air fresheners are used and help with the odours for about a week at a time and a room spray is used along the washroom baseboards but it only lasts for a few hours.
The Environmental Services Manager (ESM) was interviewed on May 22, 2014 and reported that an odour eliminator is used in the resident washrooms where odours are noted and that urine may have leaked under the old tiles in the washrooms and the home is now changing the flooring in washrooms to one piece flooring at a rate of four rooms every three months.
Despite the homes' current process for addressing incidents of lingering offensive odours, the stong urine odours persist in a particular resident washroom, and the shared washroom of two other resident rooms.

As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

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 that ensures that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. On May 12, 2014, Inspector #580 reviewed the Home's Medication Management - Drug Destruction policy V3-930 Originated March 2012, Revised April 2013. The policy states that a discontinued narcotic is to be stored in a double-locked storage area.

On May 12, 2014 at approximately 1155hrs, staff member #114 told Inspector #580 that used Fentanyl patches, removed from a resident, are disposed of in the sharps container.

On May 12, 2014 at approximately 1230hrs, staff member #110 showed Inspector #580 the non-narcotic drug discard container and the narcotic discard container and reported to the Inspector that used Fentanyl patches, removed from a resident, are disposed of in the sharps container. In addition, they also reported that the maintenance personnel remove the sharps container every Tuesday and store them in the maintenance storage closet under a single lock.

On May 13, 2014, Inspector #580 reviewed the MediSystem Pharmacy Policy and Procedure Manual (the Home's pharmacy service provider). Inspector #580 reviewed the Medication System - Narcotic and Controlled Substances, Index Number: 04-01-40, last reviewed: October 1, 2012 and the Inventory Management – Disposal of Discontinued/Expired Medications and Narcotics, Index Number: 05-02-20, last

reviewed: October 1, 2012. Inspector #580 found no policy, protocol or procedure related to the discard of used Fentanyl patches, removed from a resident.

On May 13, 2014, Inspector #580 reviewed the Narcotic/Controlled Substances Surplus Drugs forms for March 2014 and April 2014, completed by the DOC and pharmacist on March 14, 2014 and April 14, 2014 respectively and there is no recorded entry of used Fentanyl patches, removed from a resident.

The licensee failed to ensure that the drug destruction and disposal policy provides that drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and , if there are none, in accordance with prevailing practices. [s. 136. (2) 3.]

2. On May 12, 2014 at approximately 1230hrs, staff member #110 told Inspector #580 that used Fentanyl patches, removed from a resident, are disposed of in the sharps container and that the maintenance personnel remove the sharps container every Tuesday. On May 13, 2014 at approximately 0950hrs, in the medication room, staff member #115 told Inspector #580 that used Fentanyl patches, removed from a resident, are disposed of in the sharps container and picked up weekly by the maintenance person and stored in the maintenance storage closet under a single lock.

On May 13, 2014, staff member #111 showed Inspector #580 the weekly method of replacing the full, locked sharp containers with locked, empty ones, showed the locked sharps container storage room on Pier 2 and showed the Inspector that once the containers are locked, there is no way to unlock them without breaking the seal. In addition, this same staff member told Inspector #580 that once per month, on a Tuesday, at a prearranged time, one of the maintenance staff brings the containers to the home's pick up area/maintenance storage closet for a company to pick up all the full sharps containers.

On May 13, 2014, the Administrator told Inspector #580 that the contracted pharmacy company is responsible for monthly pick up of sharps containers.

Used Fentanyl patches are not destroyed by a team as required in the legislation.

The licensee failed to ensure that in the case of a controlled substance, the drugs are destroyed by a team acting together and composed of one member of the registered

nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist. [s. 136. (3) (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 that ensures that the drug destruction and disposal policy provides that drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence based practices and if there are none, in accordance with prevailing practice and in the case of any controlled substance, that the drugs are destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist, to be implemented voluntarily.

WN #5: 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. On May 06, 2014 at 1234hrs, Inspector #579 observed lunch service and noted staff member #112, remove plates from residents that were finished eating and place them in the dirty tray for removal to the kitchen and then take new servings from the servery and deliver the food with their thumb clearly into the plate to another resident. At no time was hand washing observed with this staff's actions. [s. 229. (4)]

2. On May 12, 2014 between 1140 and 1155hrs, Inspector #580 observed medication administration to five residents by staff member #114 on a particular unit and hand washing did not take place between these residents. Upon being asked by Inspector #580 regarding infection control during medication administration, the staff member replied they had forgotten to do so and usually have a handgel container on the medication cart.

The licensee failed to ensure that all staff participates in the implementation of the infection prevention and control program. [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 that ensures that all staff participate in the implementation of the infection prevention and control program, specifically staff hand washing between residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On May 6, 2014 at 1120hrs, Inspector #196 observed four black plastic hair combs in the cupboard in the common tub room on one of the units, soiled with debris. Staff member #113 was asked who the combs belonged to as they were unlabelled and they were not aware and subsequently threw them in the garbage.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. On May 7, 2014 at 1600hrs, Inspector #196 observed resident #963 lying in bed and a strong odour of feces and urine was present within the resident's room. A staff member was made aware and proceeded to assist the resident with continence care. The health care record for resident #963 was reviewed and a "pre-admission review and admission care plan" from the time of admission to the home, identified the resident as being continent of both bowel and bladder and required supervision for toileting. The most recent MDS assessment noted the resident as "frequently incontinent of bowel and bladder, use of pads or briefs" and extensive assistance of one person for toilet use. However, there was no specific assessment related to continence. Interviews were conducted with direct care staff members and they reported that resident #963 wears a continence product at all times, and that they will sometimes void on the toilet, depends on how their day is going. An interview was conducted with management staff member 101 on May 22, 2014 and it was determined that there were no continence assessments for resident #963 in hard copy or online despite this change in continence status, continent at time of admission to presently frequently incontinent of both bowel and bladder.

The licensee failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; [s. 51. (2) (a)]

Issued on this 8th day of October, 2014

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