Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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**

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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Feb 9, 10, Apr 13, May 4, 10, 17, 2012 | 2012_140158_0004 | Critical Incident |

**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**

KELLY-JEAN SCHIENBEIN (158)

## Inspection Summary/Résumé de l'inspection

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

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), families and residents.**

**During the course of the inspection, the inspector(s) reviewed residents' health care records, the home's falls prevention program, the home's responsive behaviour policy, the home's abuse policy and observed staff providing care to residents.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 subsections:**

**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;**
**(b) the goals the care is intended to achieve; and**
**(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. The written plan of care for a resident did not set out clear directions to staff and others who provide direct care to the resident.
The home reported to the MOHLTC that a cognitive resident was observed by staff to be inappropriately touching a cognitively impaired resident who was sitting alone in the lounge area of a unit, waiting to be portered by staff.
A RN identified to the inspector on February 9/12 that the cognitively impaired resident is transferred into a chair and portered to the TV lounge to wait until the staff can porter the resident to the dining room and or the resident's bedroom.
The cognitively impaired resident's plan of care does not identify or provide direction related to the risk of the cognitive resident's further sexual inappropriate touching.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]
2. The written plan of care for a resident did not set out clear directions to staff and others who provide direct care to the resident.
The Administrator identified to the inspector on February 9/12 that at times a cognitively impaired resident undresses.
The resident's plan of care was reviewed by the inspector on February 9/12 and identified that the resident has severe cognitive impairment.
Agitated behaviours such as climbing out of bed and verbal aggression were identified but did not identify the undressing behaviour.
The resident's plan of care did not address or identify interventions related to the undressing behaviour.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]
3. A resident's plan of care identified under eating " provide a peaceful and unhurried atmosphere during meals; ensure the resident is at a 90 degree angle, one staff total assist".
Resisting care is identified in the resident's plan of care and identifies the intervention "approach using a calm manner, explain prior to care what you will be doing".
The resident was observed by the inspector to be fidgeting and moving back and forth un the chair during a meal on February 9/12. The inspector observed a PSW stop feeding another resident and rushed to reposition this resident banging the back of the wheel chair's neck support without warning the resident. The resident was observed to become more agitated as a result.
The atmosphere was hurried and not peaceful. The PSW did not approach the resident in a calm manner nor provide the resident with an explanation prior to acting.
The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (7)]
4. The written plan of care for a resident did not set out clear directions to staff and others who provide direct care to the resident.
On February 9/12, staff attempted to provide care to a resident but the resident was aggressive, pushing them away and saying no.
The resident's printed plan of care was reviewed by the inspector on February 10/12 and included behaviours of physical abusive/aggression, however, it was identified that the behaviour was not exhibited and subsequent interventions were not listed. A PSW reported to the inspector that the resident made a fist towards a family member earlier that day. The PSW identified that using a calm approach, one staff can manage to give the resident care as two staff cause the resident to become more aggressive.
Resistive to care is identified related to ADLs but interventions to manage the physical aggression is not present.
Clear direction to manage the resident's aggression and resistance to care was not set out in the plan of care.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]
5. A resident was transferred to hospital after falling and sustaining injuries.
The resident's plan of care identified that the resident was a high risk to fall.
The plan of care identified that the resident required extensive assistance with weight bearing and that the resident required assistance of two staff to walk in the hall. The resident's progress notes identified, the resident, who was agitated and upset, left the dining room with the assistance of one staff and subsequently fell.
The care set out in the plan of care was not provided to the resident as specified in the plan of care.
[LTCHA 2007, S.O. 2007, c. 8, 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 ensuring that clear direction to staff and others providing direct care to the residents is set out in each resident's plan of care and that the care set out in the plan of care is provided to the resident, to be implemented voluntarily.***

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**WN #2: 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 subsections:**

**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 protect residents from abuse by anyone.
The home reported to the MOHLTC that a cognitively aware resident was observed by staff to be inappropriately touching a cognitively impaired resident who was sitting alone in the lounge area of a home area.
The inspector reviewed the cognitive resident's health care record on February 9/12 and there were six previous documented incidents where the cognitive resident inappropriately touched or made sexual gestures towards several other cognitively impaired residents in different home areas. There were also two episodes of sexual inappropriateness by the cognitive resident towards staff, post reporting of the above incident to the MOHLTC.
The cognitive resident's plan of care identifies interventions to address the sexual deviant behaviour i.e. "protect other residents, never leave resident alone with other confused residents, resident is to be monitored more closely when demented residents are near and accompany resident to and from visits with the spouse who lives in a different home area". The inspector did not observe that the cognitive resident was closely monitored or accompanied by staff when a visit with the spouse occurred on February 9/12.
[LTCHA 2007, S.O. 2007, c. 8, 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 ensuring that all residents are protected from abuse by anyone, to be implemented voluntarily.***

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**WN #3: 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 subsections:**

**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.**
**2. Every resident has the right to be protected from abuse.**
**3. Every resident has the right not to be neglected by the licensee or staff.**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**
**5. Every resident has the right to live in a safe and clean environment.**
**6. Every resident has the right to exercise the rights of a citizen.**
**7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.**
**9. Every resident has the right to have his or her participation in decision-making respected.**
**10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.**
**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.**
**12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.**
**13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.**
**15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.**
**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.**
**17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,**
**i. the Residents' Council,**
**ii. the Family Council,**
**iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,**
**iv. staff members,**
**v. government officials,**
**vi. any other person inside or outside the long-term care home.**
**18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.**
**19. Every resident has the right to have his or her lifestyle and choices respected.**
**20. Every resident has the right to participate in the Residents' Council.**
**21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.**

**22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.**
**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.**
**24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.**
**27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. A resident was not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
On February 9/12, the inspector observed a PSW speak to a resident like a child while assisting the resident at meal time.
The inspector observed the PSW to lean over the resident and curtly and loudly say " now, stop that, I told you this before ".
A resident was not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
[LTCHA 2007, S.O. 2007, c. 8, s. 3 (1)]

**Issued on this 18th day of May, 2012**

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