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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Apr 25, 2016	2016_303563_0008	000353-15	Complaint

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 - ST GEORGE
225 ST. GEORGE STREET TORONTO ON M5R 2M2

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

MELANIE NORTHEY (563), CAROLEE MILLINER (144), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 4 - 8, 2016

The following complaint inspections were completed concurrently:
Log # 000573-15 / IL-36688 related to lack of care provided
Log # 002413-15 / IL-37289 related to staff to resident alleged abuse
Log # 004522-15 / IL-37820 related to staff to resident and resident to resident alleged abuse
Log # 006176-15 / IL-38116 related to lack of pain management
Log # 010840-15 / IL-38733 related to staff to resident alleged abuse
Log # 011584-15 / IL-38860 related to rate reduction
Log # 016931-15 / IL-39377 related to improper care
Log # 020269-15 / IL-39769 related to resident complaints regarding food
Log # 026579-15 / IL-40620 related to concern for resident safety
Log # 002187-16 / IL-42673 related to improper care
Log # 003413-16 / IL-42326 related to improper care
Log # 005772-16 / IL-43022 related to improper care
Log # 009751-16 / IL-43936 related to staff to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Manager of Resident Programs, one member of the Resident Program Team, one member of the Environmental Maintenance Team, the Environmental Service Manager, the Scheduling Clerk, the Food Services Supervisor, two Receptionists, one Activation Aide, a service representative from Abel Pest Control, three Registered Nurses, six Registered Practical Nurses, fifteen Personal Support Workers, seven residents and one family member.

The inspector(s) also conducted a tour of the home and made observations of residents, resident/staff interactions, activities and care. Relevant policies and procedures, the home's investigation notes, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Responsive Behaviours

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

- **5 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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 the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of a progress note revealed resident # 061 was transferred to hospital for assessment after a critical incident.

Record review of the current care plan for resident # 061 revealed the resident was at high risk for falls.

Record review of the Quarterly Minimum Data Set (MDS) Assessment revealed a Falls Resident Assessment Protocol (RAP) where by resident # 061 required a specific number of staff to assist with transfers to and from the wheelchair.

Staff interview with a Registered Practical Nurse (RPN) # 123 revealed a new type of device was purchased that required two staff at all times. The RPN confirmed resident # 061 has since used this device and the device was not mentioned in the resident's plan of care.

Interview with the Executive Director # 107 and Director of Care # 101 confirmed the care plan intervention related to the use of the new device with two staff assistance should be in the resident's care plan to prevent this type of fall reoccurrence as an intervention in the plan of care. [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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Record review of the complaint submitted to the Ministry of Health and Long-Term Care revealed resident # 061 had a fall with an injury.

Record review of a progress note revealed resident # 061 was transferred to hospital for assessment.

Record review of the Quarterly MDS Assessment revealed resident # 061 required physical help in part of care activity and occasionally requires two staff assist using mechanical lift.

Staff interview with a Registered Practical Nurse (RPN) # 123 confirmed at the time of this incident resident # 061 did require two staff for transfers on occasion.

Staff interview with the Executive Director # 107 and the DOC # 101 confirmed that only one PSW was transferring the resident at the time of the incident and that two staff should have been present related to the resident's declined physical status. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

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:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector # 144 observed resident # 006 wearing a heavily wrinkled sweater with the right shoulder seam ripped and the resident's right shoulder exposed.

The Inspector followed the resident to their room and spoke with Personal Support Worker (PSW) # 133 who advised they selected the resident's clothing and dressed the resident on this date in the morning and was aware the resident's clothing was wrinkled and torn. The PSW expressed her concern about the resident being warm enough. The PSW further agreed the resident was not dressed appropriately and that they would change their clothing so that the resident's attire was presentable.

Registered Nurse (RN) # 134 agreed that the resident was not dressed appropriately and should not been dressed in wrinkled and torn clothing. The RN further agreed it was the resident's right to be properly dressed. [s. 3. (1) 4.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Record review of the "Prevention of Abuse and Neglect of a Resident Policy # VII-G-10.00" dated January 2015" revealed, "All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home."

Record review of the clinical record for resident # 041 revealed an incident of staff to resident abuse. Resident # 041 lodged a complaint with the Ministry of Health immediately following the incident.

Record review of the Long-Term Care Home's Critical Incident System used to report incidents to the Director, failed to identify a report related to the identified incident.

Interview with resident # 041 revealed that immediate actions were taken by the Director of Care at the time of the incident, however resident # 041 was not satisfied with the way the home handled the complaint.

The Executive Director # 107 confirmed that the incident had not been reported immediately to the Director. The Executive Director # 107 confirmed it was the home's expectation that the abuse of a resident that results in risk of harm to that resident must be reported to the Director immediately. (538) [s. 20. (1)]

WN #5: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurs that causes an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, or remained unsure whether the injury had resulted in a significant change in the resident's health condition, was to inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required.

Record review of a progress note revealed resident # 061 was transferred to hospital for assessment after a fall and reported pain.

Record review of the “Assessments” tab in PointClickCare for resident # 061 revealed a "Pain Assessment - for cognitively well 2.0" was completed related to a change in condition.

Record review of a “Physician Visit” progress note revealed ongoing pain and if pain increases to transfer resident to the emergency room.

Record review of a “Health Status” progress note and review of the “Order Summary Report” for resident # 061 revealed the resident was started on a new pain medication.

Staff interview with the Director of Care (DOC) # 101 confirmed that a Critical Incident Report should have been submitted related to this fall, transfer to hospital and change in pain status requiring medication management review and monitoring. [s. 107. (3.1) (b)]

Issued on this 26th day of April, 2016

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

Original report signed by the inspector.