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
Jun 26, 2013	2013_205129_0007	H-000316-13	Critical Incident System

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - TULLAMORE
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4, 5 and 6, 2013

During the course of the inspection, the inspector(s) spoke with residents and resident Power of Attorney, registered and unregulated nursing staff, Physiotherapist, Assistant Director of Care, Director of Care and the Administrator in relation to Log #H-000316-13.

During the course of the inspection, the inspector(s) observed residents, reviewed computerized as well as hard copy clinical records and reviewed the home's policies, procedures and program information.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident's right to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
Staff in the home had knowledge of behavioural changes occurring with a co-resident; however took no action to monitor or prevent an escalation of these behaviours and this co-resident physically abused resident #002. Resident #002's Power of Attorney indicated in a telephone interview that the resident had communicated some concerns for changes being noticed in the co-resident's behaviour, who also was resident #002's roommate, and confirmed that this information was provided to registered staff. Staff identified knowledge of the risk when they documented incidents of responsive behaviours being demonstrated by the co-resident that included physical and verbal aggression towards other residents and staff and also documented in a review of the care needs for the co-resident completed in May 2013 that the resident's behavioural symptoms had deteriorated however took no action to manage these behaviours that escalated when resident #002 was physically abused. [s. 3. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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 did not ensure that the written plan of care provided clear direction to staff and others who provide direct care to the resident, in relation to the following: [6 (1)(c)]
Personal Support Workers (PSWs) that provide direct care to residents in the home were not provided with clear directions for the provision of care to resident #002. The Assistant Director of Care (ADOC) confirmed that the systems in place in the home for providing direction to care staff with respect to managing identified needs were the computerized care plan and the point of care computerized care program. The ADOC also confirmed that PSWs are provided with care directions through the point of care computerized care program, the computerized care plan is not printed and PSW care staff do not have access to the computerized care plan. Resident #002's computerized care plan indicated that this resident had care needs related to the monitoring symptoms from multiple diagnoses, specific assistance required for activities of daily living, care related to the risk for falling and care related to the management of responsive behaviours. The ADOC confirmed that the corresponding care directions for these needs were not included in the directions for care available to PSW staff. PSW staff confirmed that they were not clear about the care directions for this resident related to the monitoring of symptoms from several diagnosis or care related to the risk for falling and the management of responsive behaviours. [s. 6. (1) (c)]

2. The licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the residents care needs change, in relation to the following: [6(10)(b)]
Data collected during a Minimum Data Set review completed in May 2013 for resident #001 indicated that the resident's cognitive status had deteriorated and the resident's behavioural symptoms had also deteriorated over the last three months. Staff also acknowledged their awareness of changes in the needs of this resident when they documented specific incidents in April and May 2013 where this resident both physically and verbally abused co-residents and staff. Staff confirmed that these behavioural incidents indicated a change in the care needs for this resident and also confirmed that the resident was not reassessed and the plan of care was not reviewed or revised based on this information. The resident's behaviours escalated and this resident physically abused a co-resident. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 did not protect resident #002 from abuse, in relation to the following: [19(1)]
Staff in the home were aware of behavioural changes being exhibited by resident #001, but took no action to assess or manage responsive behaviours being demonstrated by this resident prior to an incident of physical abuse involving resident #002 on an identified date. Resident #002 indicated that there was no physical injury as a result of the incident; however staff and this inspector noted behavioural/mood/cognitive changes in this resident following the incident. Resident #002 appeared unable to remember what happened a day following the incident and when this was questioned the Director of Care and the charge nurse confirmed that because of the resident's previous memory skills, they believe that these changes represent the resident's attempts to cope with the attack. During an interview conducted in June 2013 resident #002 became very quiet, withdrawn and emotional when the conversation moved to a discussion of the co-resident involved in this incident. Staff in the home where aware of behavioural changes being demonstrated by resident #001, when they documented in the clinical record that in April 2013 the resident was observed to be kicking a co-resident, the resident got into a verbal altercation with a co-resident that resulted in the resident punching the co-resident, in May 2013 when they documented that the resident had a strong verbal response to a minor maintenance issue, verbally abused a staff person who was attempting to provide care to a co-resident and documented on a Minimum Data Set (MDS) review completed in May 2013 that the residents behavioural symptoms had deteriorated over the previous three month period of time. Staff confirmed that they did not assess the behavioural changes and did not develop interventions to manage the behaviours being demonstrated by resident #001 prior to this incident. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Administrator and the Director of Care, who had reasonable grounds to suspect that abuse of a resident had occurred did not immediately, report the suspicion and the information upon which it was based to the Director, in relation to the following: [24(1)2]
a) The Administrator and the Director of Care did not immediately notify the Director of a suspicion that abuse of a resident had occurred, following an incident on an identified date in 2013. Clinical record documentation indicated that on this date resident #001 was involved in a verbal altercation with resident #003 that resulted in this resident punching resident #003. The home notified the Director through the Critical Incident system, identifying resident to resident abuse the following day.
b) The Administrator and the Director of Care did not immediately notify the Director of a suspicion that abuse of a resident had occurred, following a second incident on an identified date in 2013. Clinical record documentation indicated that on this date resident #001 physically abused resident #002. Staff in the home contacted the police, who attended the home and removed resident #001 from the home. The home notified the Director through the Critical Incident system, identifying resident to resident abuse the following day. The Administrator and Director of care confirmed that they did not use the emergency pager nor did they leave a message with the Hamilton Service Area Office about these incidents and also confirmed that they were uncertain about the requirements to report immediately to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for resident #001 was based on, at minimum, an interdisciplinary assessment of mood and behaviours, in relation to the following: [26(3)5]
Resident #001 was noted to be demonstrating an increase in responsive behaviours, when staff documented in the progress notes in April and May 2013 the resident was seen kicking other residents, entered into a verbal altercation with resident #003 and punched this resident, had a strong verbal response to a minor maintenance issue and verbally abused a staff person who was attempting to provide care to a co-resident. Staff also documented on a MDS review completed in May 2013 that the resident's behavioural symptoms had worsened over the previous three month period of time, however confirmed that these responsive behaviours were not assessed and no care interventions for managing these behaviours were included in the plan of care. The resident's behaviours escalated and this resident physically abused a co-resident. [s. 26. (3) 5.]

2. The licensee did not ensure that every plan of care was based on, at minimum, interdisciplinary assessment of health conditions including pain and other special needs, with respect to the following: [26(3)10]
a) Clinical documentation for resident #001 indicated that over a three month period of time in 2013 the resident received a non-narcotic medication to manage pain symptoms 15 times. During this period of time the resident indicated to staff that the sources of pain were the head and body aches. Data collected during a MDS review completed during this same time period, indicated that the resident did not have pain. Nursing staff confirmed that the resident's pain was not assessed based on data collected and the plan of care did not include pain management as a care need for this resident.
b) Clinical documentation for resident #002 indicated that over a three month period in 2013 the resident received narcotic and non-narcotic medication to manage pain symptoms 34 times. During this period of time the resident indicated to staff that the sources of pain were the back, shoulder, generalized pain, tooth pain, head and the right hand. Data collected during a MDS review completed during this same time period, indicated that the resident had pain less than daily at a moderate level over the previous three months. Nursing staff confirmed that the resident's pain was not assessed based on data collected and the resident's care plan did not include interventions for the management of pain the resident was experiencing. At the time of this inspection the resident continued to experience pain.
c) During an interview conducted at the time of this inspection resident #002 indicated

extreme pain was being experienced in the right hand. The resident's right hand appeared swollen and red across the top of the hand. A review of the clinical documentation indicated that physiotherapy had assess the resident's hand and put in place a plan to apply and ice pack to reduce swelling and manage pain; however, nursing staff confirmed they had not assessed the resident's hand, considered any diagnostic procedures to determine the extent of the injury and did not include pain issues related to the resident's right hand in the plan of care. [s. 26. (3) 10.]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :