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 soins de longue durée

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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
Jun 2, 2016	2016_282543_0015	002380-14	Critical Incident System

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 - VAUGHAN
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

TIFFANY BOUCHER (543), JENNIFER LAURICELLA (542), JESSICA WASYLENKI-RYAN (639), LISA MOORE (613), MISHA BALCIUNAS (637)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18-22, 2016 and April 25-29, 2016

This Critical Incident Inspection is related to 17 critical incidents; 12 logs related to abuse/neglect, and five logs related to improper care.

A Complaint Inspection # 2016_282543_0014 was conducted concurrently with this inspection.

For findings of non-compliance related to the LTCHA, s. 6 (1) c., please refer to the Complaint Inspection report #2016_282543_0014.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Assistant Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Dietary Staff

Throughout the inspection, the Inspectors directly observed the delivery of care and services to residents in all home areas, directly observed various meal services, reviewed resident health care records and reviewed various home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

2 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed to meet the needs of residents with responsive behaviours.

Inspector #639 reviewed the home's policy titled, "Responsive Behaviours Management-#VII-F-10.20" which indicated that the policy failed to address written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

An interview with RPN #101 (BSO Lead), confirmed that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours was not included in the Responsive Behaviours Management policy. [s. 53. (1) 2.]

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 written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, were developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist resident #017 with eating, including safe positioning of resident #017.

Inspector #542 observed resident # 017 during a meal service and noted that interventions identified in the resident's plan of care were not being implemented.

Inspector #542 interviewed RPN #110 who confirmed resident #017's plan of care intervention should have been implemented.

Inspector #542 interviewed PSW #111, who was unable to identify any of the listed interventions that were part of resident #017's care plan.

The DOC and the Manager of Volunteer Services, both confirmed that the home does not allow family members to assist with the feeding of residents that are not related to them.

Inspector #542 reviewed resident #017's current care plan which identified that the resident had a certain problem related to nutrition and hydration. The resident's plan of care included interventions that were specific to this resident's care needs.

Inspector #542 reviewed the progress notes for resident #017, which also indicated specific interventions specific to their needs.

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 proper techniques were used to assist resident #017 with eating, including safe positioning of the resident, to be implemented voluntarily.

Issued on this 8th day of June, 2016

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

Original report signed by the inspector.