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_0014	003051-15	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 - 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), LISA MOORE (613)

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 18-22, 2016 and April 25-29, 2016

This Complaint inspection is related to seven complaints. One log related to abuse/neglect. One log related to housekeeping. Five logs related to improper care.

A Critical Incident Inspection # 2016_282543_0015 was conducted concurrently with this inspection. Non-compliance found in the Critical Incident inspection related to LTCHA, s. 6 (1) c, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Assistant Director of Care (ADOC), 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:
Accommodation Services - Housekeeping
Admission and Discharge
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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. (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #543 reviewed resident #004's plan of care which identified a discrepancy related to their continence care needs. This resident's plan of care indicated that the resident required a level of assistance related to their ADLs. The plan of care also identified a certain behaviour this resident displayed.

The inspector observed resident #004 on several occasions and at no time did they observe this resident displaying a specific behaviour.

The Inspector spoke with PSW #103 regarding this resident who confirmed that resident #004's level of assistance required related to ADLs.

The Inspector spoke with PSW #102, who confirmed resident #004's continence care needs. PSW #102 confirmed this resident's the level assistance required related to ADLs.

The Inspector spoke with RPN #101 regarding this resident's plan of care. They confirmed that this resident's plan of care did not provide proper direction to staff, related to the specific behaviour, ADL and continence care needs and that the plan of care was incorrect. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The Inspector reviewed critical incident (CI) #2945-000011-16, related to resident #030 sustaining an injury.

Inspector #637 reviewed resident #030's plan of care, which indicated would maintain their current level of mobility. Under the focus related mobility the plan of care indicated that the resident required a device for mobility and was dependent on staff for mobility.

Inspector #637 observed resident #030 on several occasions; and noted a discrepancy related to the use of their mobility device and what was identified in their plan of care.

Inspector #637 interviewed RPN #100, who verified that the resident was not utilizing their device for mobility.

Inspector #637 interviewed PSW #119, who confirmed that the resident should have been using their mobility device.

Inspector #637 interviewed RN #104 who confirmed that resident #119's plan of care did not set out clear directions to staff, specifically regarding mobility. RN #104 confirmed that specific directions were not clearly displayed in the care plan.

Inspector #637 interviewed the head of the falls prevention program who confirmed that resident #119's care plan did not set out clear direction to staff related to the resident's use of a mobility device. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #017's plan of care set out clear directions to staff and others who provide direct care to the resident.

A health care record review was completed for resident #017. A specific document identified that resident #017 had displayed sign and symptoms related to nutrition and hydration and interventions were listed specific to this resident's

The progress notes for resident #017 were reviewed but did not identify all the interventions required for this resident's needs.

The current care plan identified resident #017 to have a certain problem related to nutrition and hydration. The interventions for resident #017 were specific to their needs.

Inspector #542 observed resident # 017 during a meal service and noted that the resident's intervention were not implemented according to their plan of care.

Inspector #542 spoke with the DOC who verified that the recommendations should have been included on the care plan. [s. 6. (1) (c)]

4. The licensee has failed to ensure that resident #001's substitute decision maker was given an explanation of the plan of care.

Inspector #613 reviewed a complaint received by the Director in relation to staff not communicating and keeping the substitute decision maker informed of resident #001's medical condition. The complainant stated there was no communication from the home with the family about their deteriorating medical condition.

The Inspector completed a health care record review for resident #001. The weekly assessments which were conducted by registered staff identified that resident #001's medical condition rapidly deteriorated in a short period of time. The Inspector did not locate documentation to identify that resident #001's substitute decision maker (SDM) had been informed of the severity and deterioration of their condition.

During an interview on April 25, 2016 with the DOC, who indicated it was the home's expectation that a significant change in the resident's medical condition should be reported to the Physician or Nurse Practitioner. They also confirmed that the resident's SDM should have been notified.

The home's "Change of Status, Notification of family/POA" policy identified that the substitute decision maker shall be notified of changes affecting the resident and/or changes in resident status to ensure ongoing communication between the Health Care Team and the resident and/or designate.

During an interview with the Executive Director and the DOC, they both confirmed that the registered staff should have informed the SDM of resident #001's deteriorating condition. [s. 6. (12)]

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 plan of care set out clear directions to staff and others who provide direct care to residents #004 and #030, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a response was made to the person who made the complaint with in 10 days of receiving the complaint.

Inspector #613 reviewed a complaint received by the Director in relation to staff not communicating and keeping the SDM informed of #001's medical condition. The complainant stated there was no communication from the home with the family about the resident's deteriorating medical condition.

The complainant contacted the home to voice their concern about resident #001's deteriorating medical condition and lack of communication from the home to keep the family informed about the severity of the resident's medical condition. The management of the LTC home acknowledged the complainant's concern on the same date and assured the complainant that the home would follow up and update them.

The Inspector reviewed the home's internal investigation file that identified the home completed their internal investigation. The corrective action from the home identified that the home would arrange a meeting with the multidisciplinary team and family as soon as the family and resident were available.

The SDM was contacted by the home to arrange a meeting to discuss the home's outcome of the investigation. The SDM was to get back to the home to set a date. Resident #001's health status deteriorated and they passed away.

During interviews with the Executive Director and the DOC, they both confirmed that the home had not provided a verbal or written response to the family about what they had done to resolve the complaint and they had not made further attempts to arrange a meeting with the family. [s. 101. (1) 3. i.]

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.