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

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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
May 18, 2016	2016_251512_0005	CSC #010020-14, 007486-14, 003715-14, 017283-15, 017637-15, 030733-15, 030715-15, 006688-16.	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ALTAMONT
92 ISLAND ROAD SCARBOROUGH ON M1C 2P5

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

TILDA HUI (512)

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): February 24, 25, 26, 29, March 1, 2, 3, and 4, 2016.

This inspection is related to one long-term care home complaint/response and seven critical incidents:
1) #017283-15, LTCH complaint/response (related to unexplained bruise)
2) #003715-14, Critical Incident (related to verbal abuse)
3) #007486-14, Critical Incident (related to physical abuse)
4) #010020-14, Critical Incident (related to physical abuse)
5) #030733-15, Critical Incident (related to abuse)
6) #030715-15, Critical Incident (related to responsive behavior)
7) #017637-15, Critical Incident (related to verbal abuse)
8) #006688-16, Critical Incident (related to resident's rights)

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Manager, Recreation Assistant, residents, and substitute decision maker (SDM)of resident.

During the course of the inspection, the inspector conducted observations in home and resident area, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

6 WN(s)
3 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. 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's 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 was fully respected and promoted.

Review of an identified critical incident (CI) report submitted by the home revealed a suspected physical abuse of resident #003 by PSW #113 on an identified date and time.

Record review revealed resident #003 required extensive assistance from one staff for showers. On an identified date and time, the resident and his/her spouse reported to the nursing staff that the PSW who assisted him/her during the shower had "pushed him/her on his/her shoulders while in the shower room, and was aggressive towards him/her, manhandled and treated him/her with disrespect". The home initiated an investigation and verified that the PSW had treated the resident with disrespect.

Interview with the resident and the spouse indicated the resident did recall the unpleasant experience, but not the details. The resident did not suffer any injury but felt unhappy about the experience.

Interview with PSW #113 indicated the resident had an incontinent episode and the PSW gave him/her a shower. The PSW denied pushing the resident however stated that he/she was trying to encourage the resident to cooperate during the shower.

Interview with the ADOC and the Executive Director (ED) confirmed that the PSW was verified to be treating the resident with disrespect during the shower and was disciplined. [s. 3. (1) 1.]

2. Review of an identified CI report submitted by the home revealed a suspected abuse of resident #004 by a PSW occurred on an identified date and time.

Record review revealed resident #004 required total assistance of two staff to transfer, turn and reposition in bed. Review of the resident's progress notes revealed an identified family member of the resident reported to the nursing staff at an identified time on the day of the occurrence. The resident indicated to his/her family member that the identified PSW was rough when repositioning the resident in bed, and had made remarks that the resident was too heavy. The incident was reported to the ADOC and the ED and an investigation was initiated.

Interview with the resident indicated the resident did recall the incident but not the details. The resident did not suffer any injury but felt unhappy about the experience.

Record review and interview with the ED revealed that the resident required two staff to turn and reposition in bed. On the identified shift when the incident occurred, the resident had called several times to change position. The PSW assigned to provide care to the resident on that shift responded to the calls. The PSW told the resident that he/she needed a second staff to assist with the turning. However, the resident insisted to be turned. The PSW explained to the resident the reason he/she could not turn the resident alone was because the resident was too heavy for one person to turn.

Attempts to interview the PSW were made however not successful. Interview with the ADOC and the ED confirmed that the investigation verified the PSW to be treating the resident with disrespect during the turning and repositioning in bed and was disciplined. The PSW was assigned to provide care to other residents and no long provide care to resident #004. [s. 3. (1) 1.]

3. Review of an identified CI report submitted by the home on an identified date, revealed a suspected verbal abuse of resident #006 by a PSW.

Record review revealed resident #006, with diagnosis of an identified medical condition, wanted to be independent in his/her ADLs as much as possible but would request assistance from staff when not able to perform certain activities. At times, the resident would required total assistance of two staff to transfer, turn and reposition in bed. Review of the resident's progress notes revealed the resident reported to the Executive Director (ED) on an identified date of an incident which occurred on the same day. The resident

indicated that one of the PSWs was verbally inappropriate to the resident when the resident asked for assistance to change his/her incontinent product. An investigation was initiated by the ED. It was verified that the PSW did not assist the resident with the incontinent product change as requested. The PSW was provided with retraining on abuse prevention, resident's bills of rights, customer service training and education on the diagnosis of the identified medical condition that the resident was experiencing.

Interview with the resident indicated the resident did recall the incident and the details. The resident stated he/she felt very angry that the PSW had judged the resident without knowing the limitation of his/her medical condition.

Interview with PSW #118 who was present at the time of incident confirmed that the involved PSW did not assist with the changing of the resident's incontinent product. However, PSW #118 stated he/she did not hear the conversation between the resident and the involved PSW as he/she was just walking into the room to assist the resident at the time. The resident heard some words exchanged but did not recall hearing what was said.

Interview with the ED confirmed that during the investigation, the PSW was verified to be treating the resident with disrespect. The PSW was disciplined, provided with retraining and assigned to provide care to residents on another unit. [s. 3. (1) 1.]

4. On an identified date and time during the inspection, on the hallway outside the shower room of an identified home area, the inspector observed PSW #114 pushing a clean linen cart with linen passed the entrance to an alcove outside the shower room. Resident #011 was observed coming out from the alcove in his/her wheelchair propelling him/herself, and was narrowly missed from being hit by the passing cart. The resident was observed to have a startled expression on his/her face when the resident saw the cart being pushed past him/her. The inspector spoke to the PSW who admitted that he/she should not have pushed the cart in front of the resident. The incident was reported to the MOHLTC on the date of the occurrence by using the after hours reporting phone line with reference #11504. A CI report on the incident was submitted to the MOHLTC the next day.

Interview with the resident revealed the resident was upset by the incident. The resident stated that similar situation had occurred before and it was not nice for the PSW to have done that. However, the resident stated that in general he/she felt safe and protected in the home and was happy with the home's care.

Interview with the ED confirmed that during the investigation, the PSW was verified to be treating the resident with disrespect. The PSW was disciplined and will receive retraining on resident's rights and abuse prevention. [s. 3. (1) 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 to ensure that the resident's 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 are fully respected and promoted, to be implemented voluntarily.

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:

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 has failed to ensure that residents were protected from verbal abuse by the staff in the home.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

An identified CI report was submitted by the home on an identified date of a suspected verbal abuse and neglect of resident #002 by PSW #101 five days prior.

Review of resident #002's dated written plan of care indicated that the resident required

two staff and mechanical lift to transfer from the bed to the wheelchair. Review of the resident's progress notes noted the resident had indicated he/she preferred to be up and dressed by the identified time in the morning, so he/she could attend breakfast in the dining room. Review of the CI report, the resident's progress notes, and the investigation notes provided by the home revealed on the morning of the incident, PSW #101 was assigned to provide personal care to the resident. PSW #101 arrived at work 20 minutes later than as scheduled. Record review indicated the resident was still in bed 45 minutes after his/her preferred time to be up, the resident became upset and angry and started yelling at staff passing by to get him/her up. PSW #102 responded to the call and went in the room to offer help, but was sent away by PSW #101. Review of the interview notes of the resident four days after the occurrence of the incident by the ADOC indicated that the resident reported hearing PSW #101 saying leave the resident in bed, the resident was behaving bad today and he/she needed to learn to wait. The resident stated in the interview that the resident felt someone owned him/her and he/she was being punished. The resident was assisted out of bed and up in his/her wheelchair and was 15 minutes late for breakfast in the dining room.

Record review and interviews with PSW #101 and the ADOC indicated that an investigation on the alleged abuse and neglect was conducted by the home, and PSW #101 was disciplined for not providing care to meet the needs of the resident. The Inspector interviewed PSW #101 who denied saying the above mentioned words to the resident, however confirmed that the resident was not assisted up and ready for breakfast as result of PSW #101 reporting to work late.

The Inspector interviewed the resident who could not recall the incident.

Interview with the ADOC and the ED confirmed that resident #002 was not protected from verbal abuse by PSW #101 at the home. [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 to ensure that residents are protected from verbal abuse by the staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of resident #007's progress notes indicated the resident has had various skin issues. Review of the physician's order revealed an active order for weekly skin assessment initiated on an identified date. Review of the resident's weekly skin assessments, skin and wound notes, and progress notes on point-click-care (PCC) revealed no indications of any weekly skin and wound assessments conducted on the resident during four identified periods of time.

Interview with RPN #120 indicated he/she was aware that weekly skin and wound assessments were to be conducted on the resident. The RPN confirmed that weekly skin and wound assessments were not being conducted on the resident for the above mentioned periods of time.

Interview with the ED confirmed that weekly skin and wound assessments should have been conducted on the resident as ordered. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Record review indicated a written complaint from an identified family member of resident #007 forwarded to the DOC on an identified date expressing concern of an altered skin integrity noted on the resident. The home conducted an investigation and could not identify the cause of the altered skin integrity. The written complaint was reported to the MOHLTC seven days later.

Review of the resident's progress notes indicated the resident has had various skin issues including a second issue identified by the family member. Review of the resident's current written plan of care revealed no indication of any focus, goal and interventions developed to address the identified second on-going skin issue.

Interview with the resident's family member indicated the family was concerned with the second identified ongoing skin issue on the resident's body. The home explained to the family two measures staff were taking to manage the skin issue.

Interviews with PSW #119 and RPN #120 indicated that staff were aware of the first measure that staff were using to manage the resident's skin issue. RPN #120 was not aware of the second measure that PSW were using as one of the strategies. Review of the resident's current written plan of care did not reveal the above two mentioned measures documented to manage the resident's skin issue.

Interview with RPN #120 and the ED confirmed that the resident's written plan of care did not set out clear directions to staff who provided direct care to the resident. [s. 6. (1) (c)]

2. Interviews with PSWs #101, #102, and RPN #104 indicated that resident #002 exhibited agitation and verbally abusive behaviors whenever he/she had to wait for care especially when he/she was not assisted up from the bed into his/her wheelchair in time for breakfast which was served at 8:00 a.m. RPN #104 indicated that most of the staff knew the resident's routine and would try to get the resident up by the specified time. At times, when the resident was assigned to new staff or staff from other units who did not get the resident up as he/she wanted, the resident would become verbally abusive at staff. RPN #104 stated that this behavioral trigger was identified by the consultant from a community resource agency and the strategy of getting the resident dressed and up early in the morning was recommended by the consultant. The RPN also stated that the strategy should be in the care plan.

Review of the resident's current written plan of care did not reveal the recommended strategy of getting the resident dressed and out of bed early as one of the interventions to reduce the resident's verbally abusive behavior. Recorded under activity of daily living (ADL) sleep pattern was the resident's preferred sleep and wake up times.

Interview with the ADOC and the ED confirmed that the written plan of care did not set out clear directions about when to have the resident up and ready for breakfast. [s. 6. (1) (c)]

3. Interviews with PSWs #101, #102, and RPN #104 indicated resident #002 exhibited agitated and verbally aggressive behaviors towards one particular roommate and the staff. The resident would become agitated and verbally abusive to roommate whenever roommate was receiving care by staff. Interview with Activation Assistant #106 revealed the resident indicated he/she loved the outdoor and certain outdoor activities at the admission assessment.

Record review revealed the resident was assessed by a medical practitioner from an identified community resource agency on an identified date. One of the recommendations to reduce the resident's agitation and verbal aggression was to increase his/her exposure to the outdoors, for example, time spent in the courtyard or with any outdoor programming or outings. Review of the current written plan of care did not reveal the above mentioned recommendation included as one of the strategies to manage the resident's responsive behaviors.

Interviews with the Director of Resident Program and the ED confirmed that the written

plan of care did not set out clear directions for staff to offer the resident outdoor activities. [s. 6. (1) (c)]

WN #5: 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

An identified CI report was submitted by the home on an identified date of a suspected verbal abuse and neglect of resident #002 by PSW #101 five days prior.

Interview with the ADOC revealed that the suspected abuse incident was reported to him/her by the resident four days after the occurrence and the MOHLTC was notified on the fifth day. Record review did not reveal any indication that the MOHLTC was informed immediately by the home by using the after hours reporting phone line.

Interview with the ED confirmed that the suspected abuse and neglect incident should be reported to the MOHLTC immediately. [s. 24. (1)]

2. An identified CI report was submitted by the home on an identified date and time of a suspected physical abuse of resident #003 by PSW #113 occurred one day prior.

Interview with the ADOC revealed that the suspected abuse incident was reported to the registered nursing staff by the resident and his/her spouse on the identified date and time, and the MOHLTC was notified more than 27 hours later. Record review did not reveal any indication that the MOHLTC was informed immediately by the home by using the after hours reporting phone line.

Interview with the ED confirmed that the suspected abuse incident should be reported to the MOHLTC immediately. [s. 24. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating to behaviour management.

Record review revealed that 84% of direct care staff received training related to behavior management in 2015. Interview with RPN #123 indicated he/she did not receive the training in 2015.

Interview with the DOC confirmed that 16% of direct care staff did not receive the training in 2015. [s. 76. (7) 3.]

Issued on this 11th day of July, 2016

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

Original report signed by the inspector.