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
Oct 14, 2014	2014_266527_0012	H-000631-13, H-000532-13	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 - BRAMPTON WOODS
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

KATHLEEN MILLAR (527)

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): May 15, 16, 22, 23, 26, 27 and 28, 2014.

This Critical Incident Inspection included Log #H-000631-13; H-000802-13 and H-000532-13.

There was no non-compliance for inspection #H-000532-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Directors of Care (ADOC)`, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and the Resident Relations Coordinator.

During the course of the inspection, the inspector(s) reviewed resident's records, the home's investigative notes and logs, policies and procedures, training records, personnel files, staff work schedules, and the home's video surveillance.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #012 was assessed in September 2013 as being at risk for falls due to unsteady gait. The plan of care identified the PSWs were to conduct hourly safety checks. Based on the resident's clinical record review, the hourly safety checks documented by the PSWs was incomplete. The RNs, RPNs and the PSWs confirmed the hourly checks were not performed as specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care for resident's is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure the Falls Prevention Program policy was complied with.

The 'Falls Prevention Program' policy, number V3-630 and revised September 2013 stated that the registered staff will immediately assess the resident for injury, conduct a head to toe examination, and document the assessment and actions taken in the resident's clinical record after a fall. Resident #012 had an unwitnessed fall, which resulted in a fracture. The registered staff, the Director of Care, the ADOC and the Administrator stated that registered staff were expected to conduct a head to toe examination of the resident and document on the skin and pain assessment tool. The registered staff would document their assessments in the resident's progress notes for 72 hours post incident. A review of the resident's record indicated there was no skin and pain assessment documentation as per the home's policy, and the registered staff, ADOC and the Administrator confirmed the assessments and documentation was not done for resident #012. The home's policy for Falls Prevention was not complied with. [s. 8. (1) (a),s. 8. (1) (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 the home's Abuse and Neglect of residents and the Falls Prevention policies and procedures are complied with, to be implemented voluntarily.

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 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). The licensee failed to protect resident #010 from abuse by a staff member.

In September 2013, resident #010 was visiting on another unit in the home. The resident was incontinent and their primary Personal Support Worker (PSW) brought them back to the unit. As the PSW was providing incontinence care to the resident, two other PSWs overheard the resident being yelled at and spoken to in a demeaning manner by the primary PSW. The Charge Nurse was notified and they also overheard the primary PSW shouting at the resident in a demeaning manner. The Charge Nurse intervened to stop the verbal abuse. The resident does not recall the incident. The Charge Nurse, two PSWs and the Administrator confirmed the verbal abuse of resident #010. The primary PSW confirmed that they was shouting at the resident and spoke to the resident like a child. [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 all residents are protected from abuse by anyone and are not neglected, to be implemented voluntarily.

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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports and was complied with.

The home's "Abuse and Neglect Resident" policy, number V3-010 and revised April 2013 stated that there was to be immediate reporting of abuse to the Director using the Ministry of Health and Long Term Care (MOHLTC) online Mandatory Critical Incident System reporting form during normal business hours. Based on the review of the home's investigative notes, interviews with the Administrator, ADOC and Charge Nurse, and a review of the MOHLTC critical incident reporting system, the reporting of the verbal abuse of resident #010 to the Director did not occur on the date and time of the incident. The incident occurred on a certain date in September 2013, but it was not until 24 hours later that the abuse of the resident was reported to the MOHLTC. The Administrator, the ADOC and the Charge Nurse confirmed the reporting to the Director was delayed greater than 24 hours after the abuse incident and should have been reported immediately. The home's policy and procedures for Abuse and Neglect Resident were not complied with. [s. 20. (2) (d)]

2. The licensee failed to ensure the policy to promote zero tolerance of abuse and neglect of residents contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

The home's "Abuse and Neglect Resident" policy, number V3-010 and revised April 2013 stated that the resident's condition was to be assessed and the resident's status was to be documented in the resident's clinical record. There was no documentation in the clinical record for resident #010 that an assessment was performed, and no documentation of the resident's health status. The Administrator, the ADOC, and registered staff confirmed that a skin and pain assessment should have been performed immediately after the incident of abuse and documented in the resident's clinical record. The Administrator, ADOC and registered staff also confirmed there should have been documentation of the verbal abuse incident in the resident's progress notes and there was no documentation noted. The home failed to ensure their procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents was complied with. [s. 20. (2) (e)]

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 the content of the written policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports; shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; and is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under the Falls Prevention Program and the Skin and Wound Program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) In September 2013, resident #010 was verbally abused by a staff member. There was no documented assessment in the resident's clinical record after the abuse incident. The ADOC and the registered staff confirmed there was no assessments, reassessments, interventions and the resident's responses to interventions documented in the resident's clinical record.

B) In October 2013 the PSW identified that resident #012 had a swollen left lower forearm and the resident grimaced when touched by staff. The PSW immediately notified the Registered Nurse to assess. An x-ray performed several days later confirmed that the resident had a fracture. There was no skin and pain assessment noted in the resident's clinical record. The ADOC and the registered staff confirmed there was no assessments, reassessments, interventions and the resident's responses to interventions documented in the resident's clinical record. [s. 30. (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 assessments, reassessments, interventions and the resident's responses to interventions are documented in the residents health record, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The Licensee did not ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that causes distress to the resident that could have potentially been detrimental to the resident's health or well-being; and (b) were notified within 12 hours upon the licensee becoming aware of the allegation, suspected or witnessed incident of abuse or neglect of the resident.

Resident #010 was verbally abused by a staff member in September 2013. The Administrator, the ADOC and the Charge Nurse were not able to identify when the POA was notified of the resident being verbally abused. In addition, the critical incident report submitted to the Director, does not identify when the POA was notified. There was no documentation in the resident's clinical record or in the home's investigative notes as to the date and time the POA was notified. The POA was not notified immediately of the witnessed verbal abuse of Resident #010. [s. 97. (1) (a)]

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 the residents Power of Attorney were notified immediately when there was an alleged, suspected or witnessed incident of abuse or neglect and the date and time was documented in the residents clinical record, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to include the following material in writing with respect to the witnessed incident of abuse of resident #010: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The critical incident report was submitted to the Director in September 2013 related to the witnessed verbal abuse of resident #010. In the report it was identified that the critical incident occurred on a specific date and time in September 2013. The verbal abuse did not occur on the date and time as noted in the critical incident report submitted to the MOHLTC. The actual date and time of the verbal abuse of the resident was confirmed by the Administrator, the ADOCs, the RNs, the RPNs and the PSWs. The subsequent amended critical incident reports to the Director were not corrected to reflect the actual date and time of the abuse incident. The Administrator, the ADOC, and the Charge Nurse confirmed the critical incident report inaccurate. [s. 104. (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 the critical incident information is accurate and includes a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident, to be implemented voluntarily.

Issued on this 15th day of October, 2014

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