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
Apr 19, 2016	2016_337581_0003-A1	002143-16	Resident Quality Inspection

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 - BRANTFORD
389 WEST STREET BRANTFORD ON N3R 3V9

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 9, 10, 14, 15, 16, 17, 18, 21, 22, 2016.

The following inspections were completed concurrently with this RQI. Complaint Inspection Log #'s 029541-15 related to resident care and 000807-16 related to staffing levels and Critical Incidents Log #'s 031597-15 related to responsive behaviours , 002325-16 related to duty to protect and reporting certain matters to the Director, 005095-16 related to falls prevention and management and Follow Up Log# 002147-16 to 2015_188168_0011/H-000988-14, CO #001, reg. 8(1)(b)

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Director of Dietary Services (DDS), Physiotherapist (PT), Office Manager, Resident Relation Supervisor, Recreation staff, Personal Support Workers (PSW), Environmental Service Manager (ESM), maintenance staff, dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
12 WN(s)
6 VPC(s)
1 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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home’s Falls Prevention Program, VII-G-30.00, effective date July 2015, identified in the post fall procedures that registered staff would complete the Falls Risk Assessment in the electronic documentation system within twenty-four hours of admission, readmission or significant change in status.

On an identified day in January 2016, resident #010 had an unwitnessed fall and sustained an injury. Review of the plan of care indicated that the Falls Risk Assessment was not completed when the resident was readmitted to the home. The DOC confirmed the assessment was not completed and the home did not comply with their Falls Prevention Program. (581)

B. The home’s Handling Food From External Sources policy, XI-F-10.40, last revised October 2015, indicated dietary staff would inspect food items, ensure they were properly labeled, dated, notify the DDS if food items were not properly labeled and dated and all food items that were out of date would be disposed.

On March 9 and 16, 2016, Long Term Care (LTC) Homes Inspector #585 observed expired and unlabeled food items in the residents’ refrigerator in the Forest Grove dining room which included the following:

i. Partially consumed one liter carton of chocolate milk.
ii. Partially consumed bottle of Tropicana orange juice.
iii. Yoplait creamy yogurt.
iv. Danone creamy yogurt.

On March 18, 2016, an open unlabeled bottle of Fuse brand drink and a partially consumed coffee cup were also observed in the refrigerator.

The DDS confirmed that food items above were not properly labeled and dated and expired food items were to be disposed when out of date. (632)

C. The home's policy, Resident Transfer and Lift Procedures, VII-G-20.20, last revised January 2016, stated that someone from the registered team member or designate will

conduct an initial assessment of the safest lift/transfer for the resident using the Lift and Transfer Assessment Form. To reassess the resident when there has been a change in weight bearing ability, ability to communicate, cognition, level of responsive behaviour, strength, range of motion, environment, level of participation and with any change in status affecting mobility. Transfer logo depicting the transfer or lift was to be posted, ensure logo was reflected in the plan of care and document in the progress notes when there was a change in the transfer and lifting status.

1. In October 2015, resident #004 was readmitted to the home and required a sit to stand lift. The following day the resident complained of weakness and as a result, registered staff changed the resident's transfer status to a "hoyer lift", as documented in a progress note. Review of the plan of care did not include a completed Lift and Transfer Assessment Form when the resident's transfer status changed. Interview with the ADOC confirmed that a Lift and Transfer Assessment Form was not completed, as required in the policy. (528)

2. Review of resident #011's current written plan of care indicated that the resident was a hoyer lift for transfers in and out of bed. Interview with PSW #131 and PSW #140 stated that the resident was transferred in and out of bed and on and off the toilet with the sit to stand lift. The ADOC stated that on March 9, 2016, they completed an audit and changed the resident's transfer status to a hoyer lift as the resident's medical status had recently deteriorated, changed the logo at bed side and updated the written plan of care. The ADOC confirmed they did not complete the Lift and Transfer Assessment Form or document in the progress notes that there was a change in the transfer and lifting status for the resident as required in their policy.

D. The home's Re-Admission from Hospital policy, VIII-C-10.80, last revised January 2015, identified that upon return from a hospital admission that the registered staff on duty would initiate a Re-Admission from Hospital Checklist on the day the resident returns from hospital, complete all the requirements on the checklist and forward the completed checklist to the DOC for signature and filing within three days. The re-admission checklist was to be completed, including but not limited to, a head to toe assessment on day one and vital signs were to be completed each shift for 72 hours after return from hospital.

1. Resident #004 was readmitted to the home after an extended stay in the hospital. Review of the plan of care identified that the head to toe assessment was completed three days after re-admission. Interview with the ADOC confirmed that a head to toe

assessment was not completed within 24 hours of re-admission as required in the home's policy. (528)

2. Resident #005 was admitted to hospital in August and November 2015. The re-admission from hospital policy was not complied with as required when the resident returned to the home post hospital admissions.

i. Review of the resident's plan of care identified the re-admission from hospital checklist was not completed by registered staff after both admissions to hospital.
ii. The resident did not have their vital signs completed each shift for 72 hours after return from hospital. Review of the clinical health record indicated after returning to the home in August 2015, vital signs were not taken on five out of nine shifts and were not taken on six out of nine shifts after returning to the home in December 2015.

3. Resident #010 was admitted to hospital in January 2016.

i. Review of the resident's plan of care identified the re-admission from hospital checklist was not completed by registered staff after admission to hospital.
ii. Review of the clinical health record identified that their vital signs were not taken on two out of nine shifts.

The DOC confirmed during an interview that the re-admission from hospital checklist was not completed post hospitalizations for both residents, the vital signs were not consistently completed for 72 hours on all three shifts post re-admission to the home and their policy was not complied with related to re-admission from hospital for resident #005 and resident #010. (581)

E. The home's Continence Program - Guidelines for Care, VII-D-10.00, last revised January 2015, indicated the registered staff would upon admission, annually and when there was a significant change in condition complete all documentation regarding the resident's level of bladder and bowel continence and planned interventions in the resident's record including but not limited to annual reviews, progress notes and Minimum Data Set (MDS) assessments.

Review of resident #011's plan of care identified they were toileted to promote continence. Interview with registered staff #103 stated that a bladder and bowel assessment was to be completed by registered staff annually. Review of the resident's plan of care indicated that a Bladder and Bowel Continence Assessment was not

completed in 2015. Interview with the ADOC confirmed that bladder and bowel continence assessment was not completed annually as required by the home's policy. (581) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Review of resident #011's written plan of care stated that they did not use the toilet and incontinence care was provided in bed. Interview with PSW #131 and PSW #140 stated that the resident was toileted using the sit to stand lift. Interview with ADOC on March 22, 2016, confirmed that the resident was toileted and the written plan of care did not include the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A review of the MDS assessment for resident #003 completed in January 2016, indicated resident had impaired vision and did not wear eye glasses. Review of the Resident Assessment Protocol (RAP) in January 2016 and the current written plan of care revealed the resident had impaired vision and wore glasses daily. Interview with PSW #100 stated the resident wore glasses and the resident was observed during the course of this inspection wearing their eye glasses. Interview with the RAI Coordinator confirmed that the resident did wear eye glasses and that the MDS assessment and the RAPS were not consistent with each other related to vision care. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. Review of the plan of care for resident #011 indicated they were to be transferred with two staff, total assistance with the hoyer lift. Interview with PSW #131 and PSW #140 stated that the resident was transferred with the sit to stand. Both PSW's were aware that the logo at bedside was changed to a hoyer lift but were not sure why and both staff confirmed they transferred the resident with the sit to stand lift even after the logo was changed so they could toilet the resident. Both PSW's stated the resident had been using the sit to stand lift for over six months for all transfers. Interview with the ADOC confirmed they reassessed the resident in March 2016 and changed the logo at bedside to the hoyer lift and updated the document the home refers to as the care plan. The ADOC stated they were unaware the resident was using a sit to stand lift as the resident would not be able to use a sit to stand lift. ADOC confirmed that the care set out in the plan of care was not provided after the resident's transfer status and logo was changed as the resident continued to be transferred by the sit to stand lift. (581)

B. Resident #060's Advanced Health Care Directive was a Level Four, as outlined in the document the home referred to as the care plan.
i. The home's policy "Advanced Care Directives", last reviewed January 2013, defined Level Four Directive as transfer to acute care hospital with cardiopulmonary resuscitation for witnessed arrest.
ii. After breakfast on an identified day in July 2015, the resident was seated in a wheelchair in their room when a co-resident alerted staff to come help. PSW #135 entered the room to find the resident required assistance and immediately called for help.

iii. Interview with PSW #135 during the course of the inspection revealed they observed the resident was in distress. Interview with RPN #103 identified they entered the room to find the resident in distress and notified registered staff #113 and registered staff #133. Interviews with PSW #135, registered staff #103 and registered staff #113 confirmed level four treatment was not provided and resident #060 was not provided with Level Four treatment, as outlined in the plan of care. (528) [s. 6. (7)]

4. The licensee failed to ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs changed or care set out in the plan was no longer necessary.

A. Review of resident #012’s written plan of care indicated their eye glasses were to be worn, cleaned frequently and to be removed and stored safely. The resident was observed during the course of this inspection not wearing eye glasses. Interview with PSW #106 and registered staff #107 stated that the resident had not worn glasses for a long time and there were no glasses in their room. Registered staff #107 confirmed that the written plan of care was not updated when the resident’s vision care changed and the plan was no longer necessary.

B. Review of resident #010’s current written plan of care and Kardex indicated that they were not toileted and changed in bed. Review of the Bladder and Bowel Continence Assessment in January 2016, revealed that the resident's toileting pattern was to use a bed pan. Interview with PSW #121 stated that the resident used a bed pan to promote bowel continence. Registered staff #101 confirmed that the plan of care was not updated when their continence care needs changed.

C. Review of resident’s #040 written plan of care indicated the resident required set up for eating. The Minimum Data Set (MDS) assessment from November 2015, identified that the resident required set up help only for eating. In January 2016, the MDS assessment identified that the resident required one person physical assistance with eating and from January 23 to 29, 2016, Point of Care (POC) documentation identified that the resident required no set up or physical help three times, set up help only 23 times, and one person physical assistance five times.

On March 17, 2016, the resident was observed not eating for ten minutes during lunch service. On March 18, 2016, an observation of breakfast and lunch revealed that PSW #123 provided some cueing during the dining period.

Interview with PSW #123 and RPN #137 stated that the resident required some assistance, needed to be reminded to eat and the resident’s wiliness to eat depended on their mood. Interviewed RPN #138 who stated that resident needed some assistance with feeding, confirmed that the written plan of care only listed that the resident required set up only and the written plan of care was not updated when the residents care needs changed, related to eating assistance. (632) [s. 6. (10) (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 that there is a written plan of care for each resident that sets out the planned care for the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and that the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #005 was observed during the course of this inspection in bed with both assist bed rails raised in the guard position. Review of the plan of care indicated that the resident required two assist rails raised when in bed to assist with bed mobility; however, when the two assist rails were installed in May 2015, their bed system was not evaluated for potential zones of entrapment until August 2015. Maintenance staff #114 stated when the resident was admitted to the home there were no bed rails on the bed, the ADOC requested that two assist rails be installed in May 2015 and confirmed the bed system was not assessed for zones of entrapment until over two months later. [s. 15. (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 that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #4: 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 failed to ensure that the resident who exhibited 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.

A. From November 2015, to March 2016, resident #005 was noted to have a recurring area of altered skin integrity. Review of the plan of care identified that the area of altered skin integrity required treatment every three days and weekly assessments were not completed every week as required. Interview with RPN #104 confirmed that one weekly wound assessment was not completed in the months of December 2015 and January 2016, and three weekly wound assessments were not completed in the month of February 2016. RPN #104 also confirmed the area had healed.

B. In September 2015, resident #007 was noted to have multiple areas of altered skin integrity requiring daily topical treatment and dressings. Review of the plan of care did not include weekly wound assessments for one week in the following months: October, November 2015 and January 2016 and this was confirmed during an interview with RPN #104. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible; and that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Resident #006's plan of care, effective July 2015, identified triggers and interventions for their responsive behaviours as confirmed by registered staff #108.

On an identified day in November 2015, resident #041 sustained an injury as a result of a responsive behavior by resident #006. According to registered staff #107, resident #006 exhibited the responsive behavior after being triggered by resident #041. A critical incident (CI) report submitted to the Ministry of Health and Long-Term Care in November 2015, stated resident #006 would be assessed for their behaviours and be referred to BSO to prevent re-occurance. BSO staff #134 reported they did not receive a referral to complete an assessment. The DOC confirmed a referral was not made to BSO as a strategy to respond to the resident's responsive behaviour.

On a later identified day in November 2015, recreation staff #116 reported they observed resident #006's responsive behaviors towards resident #041 and was unable to confirm whether their behavioural intervention was in place at that time.

Following the two incidents between resident #006 and resident #041, resident #006's progress notes stated a change would be made to their behavioural interventions. Interview with registered staff #103 and #130 reported that the revised interventions was added to the resident's plan of care following the first incident in November 2015; however, the change was not documented until after the second incident.

On March 17 and 21, 2016, the behavioural intervention was observed not in place. PSW #106 and housekeeping staff #132 reported the intervention had not been in place for at least two months. Registered staff #107 reported the intervention caused confusion for the resident. Registered staff #108 confirmed the intervention was not in place on March 21, 2016; however, should have been as a strategy to respond to the resident’s responsive behaviours. Registered staff #108 confirmed that actions taken to respond to the needs of the resident, including interventions and responses to the interventions were not documented. [s. 53. (4)]

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A. On March 17, 2016, at approximately 0745 hours, an unlocked medication cart was noted to be sitting outside of the Courtyard dining room. Residents were noted to be around the cart making their way to the dining room for breakfast service. On closer observation of the cart, medication tablets were noted to be in a medication cup sitting on top of the cart, along with an unlabeled syringe filled with medication. Approximately two minutes later, RPN #124 exited the nursing storage area. Interview with RPN #124 confirmed that the medications on the cart were dispensed prior to entering the storage room and the cart should have been locked when unattended with medications secured within the cart, including medication tablets and the syringe of heparin.

B. On March 14, 2016, at 1300 hours, an unlocked medication cart was observed at the end of the Cedarwood hallway by the sun room. One resident was observed approaching the cart with no staff present. Registered staff #115 confirmed only they were to have access to the cart and that it was left unlocked and unsupervised for approximately two minutes. (585)

C. On March 21, 2016, at approximately 1540 hours an unlocked medication cart was found in the small hallway outside the Main street nurses station for over two minutes. Registered staff #107 was observed up the hall near the front door on a portable telephone. The LTC Homes Inspector was able to open and close medication cart drawers without the nurse being aware and there were residents going up the hallway close to the cart. Interview with registered staff #107 confirmed the medication cart should be locked when unattended and immediately locked the cart. (581) [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be be easily seen, accessed and used by residents, staff and visitors at all times; and available in every area accessible by residents.

i. On March 22, 2016, a small metal switch was observed outside in the garden courtyard. The switch did not include signage or a rope to indicate it was a staff-resident communication and response system. Interview with recreation staff #116 confirmed the switch was part of the resident-staff communication and response system; however, it was difficult to see and know what it was for. Interview with maintenance staff #139 reported normally a rope was on the switch.

ii. On March 22, 2016, recreation staff #116 reported that the outdoor area outside the north activity room was under construction and intended for use by residents. Recreation staff #116 stated they had used it once for a recreational program and also observed families utilize the space. Maintenance staff #139 confirmed the area did not contain a resident-staff communication and response system. [s. 17. (1)]

WN #8: 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 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The plan of care for resident #007 identified that they had ongoing areas of altered skin integrity requiring daily topical treatments and dressings; however, the resident often refused treatments. Review of the electronic treatment assessment records (eTAR) from December 2015, to March 2016, identified that daily treatment was not documented as follows:

i. Eight times in December 2015
ii. Seven times in January 2016.
iii. Ten times in February 2016.
iv. Four times in March 2016.

Interview with registered staff #115, who worked the majority of the days when the eTARS were incomplete identified that the resident often refused treatment and dressings. Staff also stated that the information was passed onto evenings shift; however, was not documented. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal.

On March 9, 2016, in the dining room, resident #040 was observed with their main course in front of them which was partially consumed. PSW #100 then approached the resident and began to porter them out of the room. PSW #100 confirmed the resident was not offered dessert. The PSW then asked the resident if they wanted dessert and they requested butter scotch pudding. Dietary staff #136 confirmed the butterscotch pudding was already disposed and the planned menu item was not offered or available. [s. 71. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping procedures were developed and implemented for cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On March 9 and 17, 2016, resident #008's wheelchair was observed soiled with dried fluid debris. PSW #106 reported the home's procedure for ensuring wheelchairs were kept clean was included as part of the task list on POC. Review of the resident's plan of care revealed that the PSWs task list did not include cleaning the resident's wheelchair, which was confirmed by the ADOC. [s. 87. (2) (a) (ii)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee failed to 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 was dealt with as follows:

1. The complaint was investigated and resolved where possible and a response that complied with paragraph three was provided within ten business days of the receipt of the complaint.

2. For those complaints that could not be investigated and resolved within ten business days, an acknowledgement of receipt of the complaint was provided within ten business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph three shall be provided as soon as possible in the circumstances.

3. A response was made to the person who made the complaint, indicating;

i. What the licensee had done to resolve the complaint, or

ii. That the licensee believed the complaint to be unfounded and the reasons for the belief.

On March 10, 2016, resident #004 reported to Long Term Care (LTC) Homes Inspector #528, that two personal items had been ruined after being laundered by the home in the fall of 2015 and they were no longer able to wear them.

i. The resident also reported they notified the home at that time, in October 2015; however, no response was provided.
ii. Review of the home's complaints log from 2015 and 2016 did not include the concerns from resident #004.
iii. The home's policy, Complaints – Response Guidelines, VI-G-10.00, revised 2015, identified that all staff members who received a complaint from any source were to report it to a departmental supervisor manager.
iv. Interview with staff #129, who confirmed that the resident told them about the personal items in the fall of 2015, stated they instructed the resident to talk to the ESM, but was unsure of what happened as a result. Interview with the ESM revealed that they were unaware of the resident's concerns; however, the home usually replaced resident's items that were damaged in the laundry.

The resident's concerns were not addressed in October 2015, when they were brought forward to staff #129, as outlined in the home's policy.

2. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

On March 10, 2016, resident #004 reported to LTC Homes Inspector #528, that their two personal items had been ruined after being laundered by the home in the fall of 2015 and they were no longer able to wear them.

i. The resident also reported that they notified the home at that time, approximately in October 2015; however, no response was provided.
ii. Review of the homes' Complaints Log from 2015 and 2016, did not include the concerns from resident #004.
iii. The home's policy "Complaints – Response Guidelines, VI-G-10.00", revised 2015, identified that the home was to complete a complaint record for all verbal complaints.
iv. Interview with staff #129, confirmed that the resident told them about the personal items in the fall of 2015 and they instructed the resident to talk to the ESM, but was unsure of what happened as a result. Interview with the ESM revealed that concerns of damaged laundered items were documented in the complaint record and usually replaced by the home, but they were unaware of the resident's concerns. ESM confirmed there were no documented records of the resident's concerns related to the damaged personal items.

In October 2015, resident #004's concerns were not documented, as required in section 101(2) and the home's policy, when they brought forward concerns to staff #129. [s. 101.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A. The home's policy "Hand Hygiene, IX-G010.10", last revised January 2015, directed all staff volunteers and visitors to practice hand hygiene at the following times:
-before entering/exiting work area.
-before and after procedure involving close contact with a resident.
-before administering a medication by any route.
-between tasks and procedures on the same resident to prevent cross-contamination of different body sites.
-after removing personal protective equipment (PPE).
-after contact with body substances or specimens, contaminated or soiled items.
-after using the washroom/toilet.
-after sneezing, coughing, blowing nose.
-after touching hair, face, etc.
-after smoking cigarettes.
-whenever hands become visibly soiled with dirt, blood, or other organic material.

On March 17, 2016, during a medication administration observation, registered staff failed to complete hand hygiene as outlined in the home's policy. From approximately 0800 to 0820 hours, RPN #125 was observed dispensing and administering medications to three residents. During that time the RPN handled pills with their hands, tested a resident's capillary blood glucose, administered pills and inhalers, touched the medication cart and computer and assisted residents with ambulation. RPN #125 did not complete hand hygiene at any time during the observation. Interview with RPN #124 and RPN #125 confirmed that hand hygiene was to be completed before any medication administration and after contact with a resident. [s. 229. (4)]

Issued on this 2nd day of May, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2016_337581_0003
Log No. / Registre no:	002143-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 19, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRANTFORD 389 WEST STREET, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_188168_0011, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is complied with, specifically related to the management of falls.

This plan shall include but is not limited to:
a. re-education of front line staff regarding the new falls prevention program and its requirements
b. continue to conduct auditing activities on a schedule and frequency as determined by the licensee to ensure that staff are completing all the required assessments post fall, specifically the falls risk assessment until staff are compliant with the program.

The plan is to be submitted to Dianne.Barsevich@ontario.ca by May 7, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that the home's policy on falls prevention was complied with.

2. The Order is made based upon the application of the factors of severity (1), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the minimum risk that resident #010 experienced, the scope of two patterned incident and the licensee's history of ongoing non-compliance with a compliance order (CO) on the July 16, 2015, Complaint Inspection with r.8 (1) (b) related to the home's Falls Prevention policy.

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's Falls Prevention Policy, VII-G-30.00, effective date July 2015, identified in the post fall procedure that registered staff would complete the Falls Risk Assessment in the electronic documentation system within twenty-four hours of admission, readmission and significant change in status.

On an identified day in January 2016, resident #010 had an unwitnessed fall and sustained an injury. Review of the plan of care indicated that the Falls Risk Assessment was not completed when the resident was readmitted to the home. The DOC confirmed that the assessment was not completed and the registered staff did not comply with their Falls Prevention policy.

4. The licensee failed to comply with the order, CO#001, inspection #2015_188168_0011/H-000988-14 when they did not provide training to staff on the newly updated Falls Prevention policy by December 15, 2015. Interview with the Director of Care confirmed that front line staff completed the annual falls prevention education in their Relias learning program; however, that this program was not specific to the home's policy or the changes made to the policy. It was confirmed that front line staff were not provided training on the home's newly updated falls prevention policy as required in the order. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

Service Area Office /
Bureau régional de services : Hamilton Service Area Office