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
Jul 31, 2014	2014_378116_0007	T-536-14	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - LAWRENCE
2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4

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

SARAN DANIEL-DODD (116), ARIEL JONES (566), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 8, 15, 16, 22, 23, 24, 2014.

This inspection was performed concurrently with resident quality inspection (RQI) inspection Log #T-58-14 (2014_378116_0005). Findings of non compliance related to s.3(1)(1),s. 6(1)(c), s.8(1)(b) were issued under the RQI report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, environmental services manager, environmental services supervisor, personal support workers (PSW), registered staff, registered dietitian, dietary manager, physiotherapist, laundry aide and Power of Attorney (POA) for resident #001.

During the course of the inspection, the inspector(s) observed staff to resident interactions, provision of care, medication administration, lunch meal service, reviewed the health record of resident #001 and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Training and Orientation

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 O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated when:
1. A change of 5% of body weight, or more, over one month
2. A change of 7.5% of body weight, or more, over three months
3. A change of 10% of body weight, or more, over 6 months
4. Any other weight changes that compromises their health.

The licensee failed to ensure that appropriate action was taken and outcomes evaluated when resident #001 experienced a change in body weight over one month. Record review revealed that resident #001 was at high nutritional risk. The resident's recorded weight reflected a 9.3kg decrease over an identified one month period.

The home's Weight Monitoring policy (number V3-1510, revised May 2013), states that staff are to ensure that a reweigh is taken immediately for all residents with an unanticipated weight change (loss or gain) of 2.0kg or more. Two further reweighs were undertaken on identified dates, that confirmed the weight loss.

An interview with an identified registered staff revealed that the resident was not a good eater and received supplements to promote weight gain. The identified registered staff confirmed that a reweigh and a referral to the registered dietitian (RD) was not completed immediately.

An interview with the current RD confirmed that the weight change was significant and could compromise a resident's health status. An interview with the DOC confirmed that by the 10th of the month all reweighs and referrals to the dietitian should be completed to ensure appropriate actions are taken and resident outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.](566)

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 actions are taken and outcomes evaluated when residents experience significant weight changes as specified in the regulations, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

Review of resident #001's progress notes and letters for identified dates, revealed POA's concerns regarding transfers, care and negative interactions between the resident and staff members.

An interview held with the DOC confirmed that the home's process for managing complaints was not followed. The concerns were not investigated and a response was not provided within 10 business days. [s. 101. (1) 1.] (116)

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 every written complaint made to the licensee or a staff member concerning the care of a resident has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of resident #001's health record revealed that an identified registered staff member administered an identified medication to the resident.

Further record review confirmed that there was no physician's order in place for the administered medication to resident #001.

The DOC confirmed that the identified medication was administered to resident #001 without being prescribed by a physician. [s. 131. (1)] (513)

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to give or refuse consent to any treatment, care or services for which his/her consent is required by law and to be informed of the consequences of giving or refusing consent.

Review of resident #001's health record indicated that he/she was cognitively intact and capable to make informed decisions regarding his/her care. The written plan of care identified that the resident had episodes of constipation.

A review of resident #001's health record revealed that an identified registered staff member administered an identified medication on a specified date, despite resident #001's refusal.

An internal investigation was conducted which confirmed that the registered staff had administered the medication without the resident's consent.

An interview held with the DOC confirmed that the administration of the medication without the resident's consent contravened the resident's right to give or refuse consent to treatment. [s. 3. (1) 11. ii.] (513)

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

A letter from resident #001's Power of Attorney (POA) was sent to the licensee's Chief Executive Officer (CEO) regarding concerns with care of resident #001 and operations in the home. Interviews held with the Administrator and the DOC confirmed that a copy of the written complaint was not forwarded to the Director. [s. 22. (1)] (116)

Issued on this 9th day of September, 2014

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