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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2015	2015_321501_0009	T-1697-15	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 - O'CONNOR COURT
1800 O'Connor Drive East York ON M4A 1W7

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589)

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 30, 31, April 1, 2, 7, 8, 9, and 10, 2015.

The following critical incidents were inspected: T-784-14 and T-1119-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of nursing (DON), associate directors of nursing (ADOC), director of resident programs, director of dietary services (DDS), food service supervisor (FSS), resident relations coordinator, registered staff, personal support workers (PSW), cook, dietary aides, residents and substitute decision makers.

The inspectors conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of clinical health records, complaint and critical incident record log, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
4 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 that fully recognizes their individuality and respects their dignity is fully respected and promoted.

On April 7, 2015, the inspector observed in an identified dining room at lunch, residents #41 and #42 both of whom require feeding assistance, waiting to be served from 12 noon to 12:41 p.m. Another resident at the table who did not need assistance, was served soup while residents #41 and #42 watched him/her eat. At 12:41 p.m. residents #41 and #42 were served their entrée without being offered their soup. Staff interview revealed that this happened due to staff being unavailable to assist these residents when the soup was served and when someone was available, they assumed the soup had already been served. Staff interviews including the DDS and DON confirmed that waiting to be served for such a long time and not offering all menu items did not fully respect and promote resident #41 and #42's right to be treated with courtesy and respect. [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 that fully recognizes their individuality and respects their dignity is 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. 6. Plan of care

Specifically failed to comply with the following:

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 has failed to ensure 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.

It was observed throughout this inspection that resident #2 was seated in an identified dining room at a table alone. Record review revealed that this was not part of his/her plan of care and there was no evidence of an assessment. Interviews with PSWs and an identified registered staff revealed resident #2 sits alone due to behaviours. Interviews with the RD and DDS revealed they were aware that resident #2 sits alone in the dining room but were unsure why. Interview with the DON confirmed that nursing and dietary staff did not collaborate with each other in the assessment of resident #2 to sit alone in the dining room. [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

On April 7, 2015, the inspector observed that resident #41 was served juice at morning nourishment and fish at lunch. Record review of the plan of care revealed that the resident does not like juice or fish and the RD has recommended milk at morning, afternoon and evening nourishment times. Staff interviews revealed they were unaware of these preferences and recommendations.

Interviews with five PSWs on different units revealed they were able to access the kardex in Point of Care (POC), but were unable to access the entire plan of care in Point Click Care (PCC). These PSWs and an identified registered staff indicated that they were aware that the kardex is an abbreviated form of the plan of care and that, in order to view the entire plan of care, PSWs need to access the computers at the nursing station. The PSWs further indicated they have had training to do this but had forgotten, as it is not something they do on a regular basis. Further interviews revealed paper copies of the plans of care were no longer available. Interview with the DON confirmed that staff should be able to access the entire plans of care and even though training for this has been provided, there needs to be follow up. [s. 6. (8)]

3. The licensee has failed to 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 the resident's care needs change.

Record review for resident #1 revealed that he/she is sensitive to environmental noise and when he/she hears people talking, thinks they are talking about him/her. Resident #1 is accustomed to having a private care giver and can be resistive to new environments and routines.

Interview with an identified registered staff and PSW revealed that prior to admission, resident #1 had a private care giver with him/her daily and continues to have a private care giver in the home from to assist with his/her adjustment to a new environment and routines.

Further review of the written plan of care for resident #1, revealed that the use of a private care giver was not indicated in the written plan of care.

Interview with an identified registered staff and DON confirmed that the use of a private care giver should have been in resident #1's written plan of care. [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 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, that staff who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, and that the resident is reassessed 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, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the planned menu items are offered at each meal and snack.

On March 30, 2015, during the lunch meal in an identified dining room, the inspector observed that residents on puree diets received mashed potatoes instead of the puree bread that was on the planned menu. Interview with the staff serving the mashed potatoes revealed that residents prefer mashed potatoes but, it is not part of their plan of care.

Record review and interview with the DDS and RD revealed that residents during the Food Committee meeting in October 2014, have requested to have mashed potatoes at

lunch and dinner meals. Interview with the RD and DDS confirmed that the serving of mashed potatoes is an option that should be care planned or should be an alternative requested at the point of service. Interview with the DDS confirmed that mashed potatoes should not be served to all residents receiving puree textured diets.

On the same day during the same meal, the inspector observed that resident #40 who was having lunch in his/her room was not offered a choice of the planned menu items by the PSW. Interview with the PSW revealed that the family has requested that when the resident has had an identified food item for breakfast, he/she is not to have the same food item for lunch so that is why he/she did not offer the resident this particular item. Record review and interview with the PSW revealed that this has not been made part of resident #40's plan of care. Interview with the DDS confirmed that all residents should be offered a choice unless it is in their plan of care.

On April 2, 2015, the inspector observed that residents in the Melody Lane dining room were not being offered shredded cheddar cheese with their chili entrée as per the planned menu. Interview with the DDS revealed that shredded cheddar cheese was available but was left in the refrigerator. The staff then proceeded to offer the cheese to those plates already served and those about to be served.

On April 7, 2015, the inspector observed that in an identified dining room residents #41 and #42 were not offered tomato soup at lunch as per the planned menu until the inspector pointed this out. Staff interviews revealed that these residents were missed because no one was available to assist them at the time the soup was being served. Interview with the DDS confirmed these residents should have been offered soup when someone was available to assist them.

On the same day during the same meal, the inspector observed that residents #41, #42, and #43 were offered the puree fish entrée with puree vegetables and mashed potatoes. Review of the therapeutic menu revealed that puree bread is also to be served with this entrée. Interview with the FSS and DDS confirmed that puree bread should have been offered to these residents. [s. 71. (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 the planned menu items are offered at each meal and snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menu is communicated to residents.

On April 7, 2015, the inspector observed there was no weekly menu posted in the Melody Lane dining area. Interview with the RD confirmed this weekly menu was missing from the bulletin board that communicates the daily and weekly menus. Interview with the DDS revealed that residents often take the weekly menus from the bulletin board. The FSS and DDS confirmed that dietary aides who change the daily menus should communicate when the weekly menu is missing so that it can be replaced. [s. 73. (1) 1.]

2. The licensee has failed to ensure that proper techniques are used to assist the resident with eating.

On April 7, 2015, the inspector observed an identified PSW standing while assisting resident #41 to drink a glass of juice at nourishment time in the TV lounge. It was also observed that an empty chair was available for the PSW to sit while assisting this resident. Interview with the PSW revealed he/she sometimes stands when assisting residents with nourishments. Review of the home's policy #V9-305 titled Mealservice-Eating Assistance protocol for residents requiring total assistance at meals and snacks revised February 2013, states that an individual providing assistance for resident(s) should be sitting at eye level and should sit down while providing eating assistance for the resident; if you stand the resident needs to tilt their head upward which increases the risk of aspiration by opening the airway. Interview with the DDS and RD confirmed staff should be seated and at eye level when assisting residents to eat or drink. [s. 73. (1) 10.]

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 weekly menu is communicated to residents and that proper techniques are used to assist the resident with eating, to be implemented voluntarily.

WN #5: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On April 6, 2015, the inspector observed the medication administration-narcotic count. The count of the individual narcotic record did not match the number of the narcotic medication from the container.

Interview with the registered staff member revealed that the following medications were removed and given to the residents in the 8:00 a.m. medication pass but was not documented on the control and narcotic records at the time the medication was removed from the container up until the inspector reviewed the control and narcotic records at 12:30 p.m.:
Fentanyl pouch 100 milligrams
Morphine SR-30 milligrams
Morphine SR-100 milligrams.

Review of the home's policy #V3-920 titled Medication Management-Controlled and Narcotic Medication revised April 2013, indicates that at the time of administration of a controlled or narcotic medication, the nurse is to complete the documentation on the control and narcotic records at the time the medication is removed from the container. Following the administration of the medication, the nurse completes the documentation on the resident's Medication Administration Record (MAR).

Interview with the DON and the Pharmacist Consultant confirmed that the control and narcotic records must be documented upon removing the controlled or narcotic medication from the container.

Interview with the identified staff confirmed that he/she did not document on the control and narcotic records at the time the medication was removed from the container according to the policy. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu items are prepared according to the planned menu.

On March 30, 2015, during the lunch meal in an identified dining room, the inspector observed that residents on a puree diet were not served pureed vegetable quiche as per the planned lunch menu. Interview with the cook confirmed that an egg mixture with bread crumbs was used for this planned menu item. Review of the recipe states to puree a slice of vegetable quiche with milk in a blender or food processor. Interview with the DDS confirmed that the cook had not followed the recipe for this item and had not prepared the item according to the planned menu.

On the same day during the same meal, the inspector observed that those receiving puree vegetables were served puree mixed vegetables at lunch. Review of the planned menu revealed that either puree broccoli or yellow beans were to be served. Interview with the DDS confirmed that the cook had run out of frozen broccoli so added mixed vegetables to the puree version of broccoli. [s. 72. (2) (d)]

WN #7: 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 has failed to ensure drugs are stored in an area or a medication cart, that is secure and locked.

On April 2, 2015, the inspector observed in an identified home area, a treatment cart left unattended and unlocked in the hallway. The inspector was able to access and open the drawers finding that the top two drawers contained multiple containers and tubes of medicated treatments, labeled with identified resident names. The remaining three drawers contained assorted dressing supplies and stock wound cleansing solutions.

Interview with an identified registered staff and the DON revealed and confirmed that when a medication or treatment cart is left unattended it is to be locked at all times. [s. 129. (1) (a) (ii)]

Issued on this 23rd day of April, 2015

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

Original report signed by the inspector.