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

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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 15, 2013	2013_162109_0028	T-18-13/T-37-13	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 - ST GEORGE
225 ST. GEORGE STREET, TORONTO, ON, M5R-2M2

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

SUSAN SQUIRES (109), AMANDA WILLIAMS (101), MONICA NOURI (193)

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): June 6, 11, 18, 19, 24, 25, July 2, 5, 8, 9, 2013

During the course of the inspection, the inspector(s) spoke with Director of Administration, Director of Care, Nurse Manager, Activation Manager, Activation staff, Registered staff, Personal Support Workers, Physiotherapist, resident, external spiritual practitioner, Dietitian, Public Guardian Investigator, family members, Staff Education Coordinator, RAI Coordinator

During the course of the inspection, the inspector(s) Conducted observations on the care unit, completed record review for resident # 1, reviewed education records, reviewed complaints and critical incidents related to resident # 1.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 :

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

Resident # 1 has been assessed as being incontinent of bowel and bladder functions. He/she has been assessed as needing medium-sized briefs.

Resident # 1 was wearing a large brief instead of a medium brief on an identified date. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care related to spiritual care is provided to the resident as specified in the plan.

Resident # 1 practices a specified spiritual activity on a daily basis provided to him/her by the family member. On an identified date the resident's family member could no longer provide the spiritual care activity. The family then provided spiritual care exercises and scriptures on an audio device to be provided to the resident daily while he/she is lying in bed.

The plan of care interventions for Spirituality states that the staff will encourage resident to participate in spiritual care through an external provider. The Activity plan of care states that an external consultant would come to the home to provide the specified services to the resident. The plan of care also states that the resident would have his/her earphones to listen to the scriptures when the resident is alone in bed.

The licensee has not arranged for an external service provider to ensure resident has spiritual care practices as stated on the plan of care.

The audio device earphones were not applied to the resident's ears to ensure that he/she could listen to scriptures on several identified dates while the resident was observed to be alone in his/her bed. [s. 6. (7)]

WN #2: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who is at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from the hospital.

Resident # 1 identified as being at a high risk for skin breakdown and who has a prior history of pressure ulcers did not receive assessments from the registered nurse upon return from the hospital for several identified occasions.[s. 50. (2) (a) (ii)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 85. Religious and spiritual practices

Specifically failed to comply with the following:

s. 85. (1) This section applies to the organized program for the home to give residents reasonable opportunity to practise their religious and spiritual beliefs required under section 14 of the Act. O. Reg. 79/10, s. 85 (1).

s. 85. (2) Every licensee of a long-term care home shall ensure that the program includes arrangements to provide worship services, resources and non-denominational spiritual counselling on a regular basis for all residents who desire them based on availability within the community. O. Reg. 79/10, s. 85 (2).

s. 85. (3) The licensee shall ensure that,
(a) mechanisms are in place to support and facilitate residents' participation in the program; O. Reg. 79/10, s. 85 (3).
(b) arrangements are made for one-to-one visitation, according to the resident's wishes, based on availability within the community; and O. Reg. 79/10, s. 85 (3).
(c) arrangements are made to facilitate the participation in the program of residents who have hearing or visual impairments, based on availability within the community. O. Reg. 79/10, s. 85 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 1 was given reasonable opportunity to practice his/her religious and spiritual beliefs required under section 14 of the Act.

Section 14 of the Act states the following:
Every licensee of a long-term care home shall ensure that there is an organized program for the home to ensure that residents are given reasonable opportunity to practice their religious and spiritual beliefs, and to observe the requirements of those beliefs.

Resident # 1 practices a specified spiritual activity on a daily basis which includes listening to scriptures and physical exercises. The resident's family member provided to the home scriptures via an audio device for the staff to ensure that the resident had 10 or more hours of scripture to listen to daily.

The licensee did not apply the audio device with scriptures on several identified dates and times that the Inspector observed the resident.

The program staff stated that they only apply the audio for one hour twice per week. The nursing staff stated that they apply the audio every day, however on the specified dates and times, the audio device was not applied. [s. 85. (1)]

2. The licensee failed to ensure that the spiritual care program includes arrangements to provide worship services, resources and non-denominational spiritual counselling on a regular basis for all residents who desire them based on availability within the community.

The licensee has access to a specified office located close to the home where specified spiritual worshipers hand out pamphlets which include contact names and numbers for the specified spiritual care practitioners. Inspector contacted a a specified practitioner who stated that the service could be provided to the resident in the home.

The licensee has not arranged for the resident to receive specified spiritual service since the resident's family member is no longer able to provide the activity. [s. 85. (2)]

3. The licensee failed to ensure that arrangements were made for one-to-one visitation, according to the resident's wishes, based on availability within the community.

The licensee has not arranged for resident # 1 to have a specified practitioner come to the home to provide the resident with one-to-one visitation. [s. 85. (3) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are provided training in skin and wound care.

There were only 110 of the 174 direct care staff trained in skin and wound care in the past year. [s. 221. (1) 2.]

2. The licensee failed to provide training related to continence care and bowel management to all staff who provide direct care to residents on an annual basis, or based on staff's assessed training needs.

There are currently 174 care staff providing direct care to the residents. According to the staff education coordinator, continence care training was offered on September 17, 2012, and on January 28, 2013.

There were only 62 out of 174 staff that attended the 2 in-services.

There was no assessment for staff training needs.

There is no tracking in the home to determine which employees have had the training and which employees need the training. [s. 221. (1) 3.]

Issued on this 19th day of July, 2013

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