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

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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
Nov 12, 2014	2014_237500_0019	T-065-14	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 - ST GEORGE
225 ST. GEORGE STREET, TORONTO, ON, M5R-2M2

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

NITAL SHETH (500), JANICE PITTS (587), SARAN DANIEL-DODD (116), VALERIE PIMENTEL (557)

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): September 15, 16, 17, 19, 22, 23, 24, 25, 26, 2014.

Additional inspections related to the complaint Log #T-371-14, and T-579-13, and T-688-14 and CI T-415-13 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), associate director of care (ADOC),food service manager (FSM), food service supervisor (FSS), director of program services, director of environmental services, MDS- RAI coordinator, house-keeping supervisor, pharmacist,receptionist, smoking attendant, registered nurse (RNs), Registered practical nurse (RPNs), personal support workers (PSWs), dietary aide, and house keeping staff, residents and family members.

During the course of the inspection, the inspector(s) observed resident's care area, reviewed residents and home records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

A review of resident #1's plan of care does not indicate any information about the resident's visual impairment and wearing glasses.

Interview with the resident confirmed that he/she has reading glasses and they are stored in his/her room.

Interview with the PSW confirmed that he/she has never seen the resident wearing glasses and does not know if the resident has glasses.

Interview with the registered nursing staff confirmed that there is no information about the resident's glasses in the plan of care despite the fact that the resident's plan of care should be based on the assessment of the resident.

Interview with the RAI Coordinator confirmed that the plan of care should be based on the assessment of the resident and the information about the glasses should be included in the plan of care of the above mentioned resident. [s. 6. (2)]

2. 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.

Review of resident #14's plan of care revealed that pureed texture should be provided to the resident.

Observation conducted on September 15, 2014, at 12.00 p.m., on an identified floor dining room revealed that the resident was served minced texture.

Interview with the FSM confirmed that the resident's diet is pureed texture and dietary aide and nursing staff should ensure that the pureed texture should served to the resident, as indicated in the resident's plan of care. [s. 6. (7)]

3. The licensee failed to 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.

Observation conducted on September 15, 2014, at 12.00 p.m., on an identified floor dining room revealed that the resident was served minced texture.

Review of resident #14's plan of care revealed that pureed texture should be provided to the resident.

Interview with the dietary aide, PSW, and registered nursing staff confirmed that they were not aware of the resident's texture as indicated in the plan of care. All staff interviewed indicated that the resident is on minced texture.

Interview with the FSM confirmed that the staff should be aware of the resident's diet and texture and need to make sure that the resident is served the correct diet and texture. [s. 6. (8)]

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 care set out in the plan of care is based on an assessment of the resident, care set out in the plan of care is provided to the resident as specified in the plan, and staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

Record review of resident #11's plan of care revealed that the resident was assessed by the dental services in 2009. There is no documentation available in the plan of care indicating that the resident was offered an annual dental assessment in 2010, 2011, 2012 and 2013. [s. 34. (1) (c)]

2. Record review of resident #1's plan of care revealed that the resident was assessed by the dental services in 2012, and in 2014. There is no documentation available in the plan of care indicating that the resident was offered an annual dental assessment in 2013. [s. 34. (1) (c)]

3. Record review of resident #12's plan of care revealed that there is no documentation available in the plan of care indicating that the resident was offered an annual dental assessment in 2012 and 2013.

A review of the home's policy #V3-1110, titled Personal care- Oral Hygiene, revised on April 2013, indicates that "each resident will receive an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision maker, if payment is required."

Interview with the registered nursing staff confirmed that he/she could not find any documentation about the above mentioned residents to offer annual dental assessments in the respective mentioned years.

Interview with the DOC and ADOC confirmed that the above mentioned residents were not offered annual assessments in the respective mentioned years. [s. 34. (1) (c)]

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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #3: 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.

Review of the home's policy entitled 'Medication Management- Controlled and Narcotic Medications' (Policy #V3-920) directs registered staff to complete the documentation on the control and narcotic records at the time the medication is removed from the container and administered to the resident.

On September 22, 2014 at approximately 11:20 a.m., the inspector reviewed the narcotic and controlled substance administration record /count sheets and observed the following discrepancies:

Resident #7
-hydromorph contin 18 mg, to be administered at 8.00 a.m., was documented as six

remaining however, there were five pills available.
- hydromorph 2mg to be given every four hours as needed was documented as 18 pills remaining however, there were 19 available in the package.

Resident #8
- hydromorph contin 3 mg, to be administered at 8.00 a.m., was documented as five pills remaining and there were six pills available in the package.

Resident #9
- lorazepam 0.5 mg to be given every four hours as needed was recorded as ten remaining and there were nine available in the package.

Interview with the registered nursing staff assigned to the medication cart confirmed that the narcotics and/or controlled substances were administered to the residents at the prescribed time however, the records were not signed at the time of administration to the above mentioned residents. The registered nursing staff signed for all of the administered narcotics/controlled substances in the presence of the inspector and was aware of the homes expectation to document at the time of administration.

Interviews with the ED and the ADOC confirmed that the registered nursing staff did not comply with the homes policy regarding documenting at the time of administration for all narcotics/controlled substances. [s. 8. (1)]

2. The home's policy titled "Medication Management, Drug Destruction", V3-930, dated April 2013, stated that the following: medications will be identified, destroyed and disposed of include: expired medications. The policy further indicated that medications that are to be destroyed and disposed of are to be stored safely and securely.

The inspector observed in the medication fridge the following: 70 vials of influenza vaccine that expired in July 2014. These medications were not stored safely or securely.

The ADOC, the infection prevention and control team lead confirmed that these medications should have been destroyed at the time they were expired and the procedure for destruction should have been followed. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, equipment is kept clean and sanitary.

Observation conducted on third floor on September 16, and 24, 2014, at 2.30 p.m., revealed that resident #3's wheel-chair was to be soiled on the seat, frame and sides.

Interview with the registered nursing staff confirmed that the wheel-chair was "quite dirty" and required cleaning.

Interview with the director of the environmental services confirmed that the nursing staff need to identify the wheel-chair to be cleaned and clean it as necessary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observation conducted on third floor shower room, on September 17, 2014, at 11.00 a.m., revealed that the paint was peeled off on door and there were broken tiles on the walls. The wall guard was observed in a damaged condition and in need of repair on third floor,outside of the elevators.

Interview with the director of the environmental services confirmed that he/she was not aware and it needs to be fix and repair. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the dental and oral status, including oral hygiene.

A review of resident #12's plan of care indicates the mouth wash to be used for the resident as the resident does not have any teeth.

Interview with the PSW confirmed that the resident has some teeth and the staff needs to use a tooth brush for the resident to provide mouth care and oral hygiene.

Interview with the registered nursing staff confirmed that the information provided in the plan of care indicating that the resident does not have any teeth is incorrect and the plan of care should have been developed based on the assessment of the resident.

Interview with the RAI Coordinator confirmed that the plan of care should be based on the assessment and information about the resident having some natural teeth and that information should be included in the plan of care of the above mentioned resident. [s. 26. (3) 12.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is dressed appropriately, suitable to the time of day and in accordance with his/her preferences, in his/her own clean clothing.

Observation conducted on September 15, 2014, at 11.00 a.m., revealed that resident #4 was dressed inappropriately. The resident was wearing pants with the hem worn through, and a dirty stained top.

Interview with the registered nursing staff confirmed that the resident is sometimes resistive for dressing and grooming and he/she might get dressed by him/herself, however, the damaged clothing should be identified by the PSW and removed from the resident's room. [s. 40.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complies with the policy and procedure of safe operation related to dining and snack service.

Review of the home's policy #V10-713, titled Daily Food Temperature Audit, revised on April 2012, indicates that "The Food Service Manager/ Food Service Supervisor shall ensure that the food and fluid temperatures are taken for each meal prior to distribution to the residents. The Food Service Manager/ Food Service supervisor shall assign a duty to the Dietary Aide."

Observation conducted on September 15, 2014, at 12.00 p.m., on an identified floor dining room revealed that the dietary aide did not take food temperature before start serving second seating.

Interview with the dietary aide confirmed that he/she took the temperature prior to serving first seating. He/she documented those temperature readings in first seating column on the Daily Food Temperature Audit Form. At the same time, he/she also documented same temperature readings for second seating column as well. He/she did not actually measure the food temperature before serving to second seating.

Interview with the FSM confirmed that the dietary aide should measure the food temperature prior to serving second seating and document at the same time. [s. 72. (7) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the medical director, the administrator, the director of nursing and personal care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the homes Professional Advisory Committee (PAC) Minutes for 2013/2014 and interviews held with the ED and DOC confirmed that an annual evaluation of the effectiveness of the medication management system was not conducted by an interdisciplinary team which includes the members set out in the legislation. [s. 116. (1)]

WN #9: 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 that 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.

On September 22, 2014, at approximately 11.15 a.m., the controlled substance cupboard located in the bottom drawer of the medication cart on the 5th floor was observed to contain a paper towel lodged in between the cupboard cover preventing it from locking.

Interviews held with the registered staff member assigned to the medication cart, ADOC and ED confirmed that controlled substances are to be double-locked at all times within the medication cart when not in use. [s. 129. (1) (b)]

Issued on this 27th day of November, 2014

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

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