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
Jul 25, 2014	2014_299559_0014	T-198-14	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 - VAUGHAN
5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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

ANN HENDERSON (559)

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 12, 13, 2014.

During the course of the inspection, the inspector(s) spoke with executive director(ED), director of care (DOC), assistant director of care (ADOC), nurse manager, registered staff, personal support worker (PSW), family and residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, complaint records, reviewed policies Falls Prevention Program V3-630, Restraint and Personal Assistance Service and Devices Physical policy V3-1340 and Abuse and Neglect V3-010.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse is immediately investigated.

Resident #001 had told his/her family that someone had hit him/her on an identified date. The family member reported this to the nurse. A family member further revealed to the nurse that the resident had also complained to him/her about being slapped during a previously identified month and in an interview revealed it had stopped when an identified PSW had moved to a different floor. The ED and DOC revealed that there had been an investigation on an identified date, which identified that there were concerns with the identified PSW, however, the investigation conducted did not address any allegations of abuse.
Clinical documentation on an identified date, revealed that the nurse had informed the nurse manager of the alleged incident on the same day. The ED and DOC confirmed they did not investigate, respond or act to the alleged abuse of the resident as they felt that the nurse's assessment was sufficient and did not require further investigation. [s. 23. (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 that every alleged, suspected or witnessed incident of abuse is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

On an identified date, resident #001 had told his/her family that someone had hit him/her in the morning. The family member reported this to the nurse. A family member further revealed to the nurse on this day, that the resident had also complained to him/her about being slapped during a previously identified month and that he/she had been complaining of abuse since he/she was admitted.

Clinical documentation on an identified date, revealed that the nurse had informed the nurse manager on the same day of the alleged incident. The ED and DOC confirmed the suspicion of abuse was never reported to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that abuse has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director, 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 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.

Resident #001 is physically and cognitively impaired and requires extensive assistance by staff for transfer and care. PSWs revealed that 2 ¼ bed rails are in up position at all times when the resident is in bed, however, the resident is unable to use them to assist himself/herself and are used by staff when providing care to the resident. Staff revealed in interviews the resident frequently attempts to crawl around the bed rails, hang his/her legs or arms over the bed rails when attempting to get out of bed.
Review of clinical records and interviews indicated that on an identified date, a right temporal bruise was noted and attributed to the possibility that this occurred earlier when the resident attempted to climb out of bed. On an identified date, padding was applied to the bed rails for comfort.
Clinical documentation, pictures provided by the family and interviews identified there had been bruising of unknown origin identified on identified dates.
Registered staff confirmed that the bed rails used by the resident had not been assessed and his/her bed system had not been evaluated in accordance with evidence based practice to minimize risk to the resident. [s. 15. (1) (a)]

Issued on this 25th day of July, 2014

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