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 7, 2015	2015_219211_0006	T-1946-15	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

JOELLE TAILLEFER (211)

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): March 5, 6, 9, 11, 2015

During the course of the inspection, the inspector(s) spoke with executive director (Interim), director of care (DOC), assistant director of care (ADOC), administrative manager, nurse manager, registered staff, registered dietitian, resident relations coordinator, personal support workers (PSW), and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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:
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 has failed to ensure that the resident's substitute decision-maker participated fully in making any decision concerning any aspect of his or her care.

Interview with resident #1's family member indicated that the home did not communicate with them about the resident's change in condition for the past three days when he/she refused to eat and drink.

Review of the food intake consumption record revealed that resident #1 ate one meal on an identified date. Review of the food intake consumption for the next day, revealed that he/she started refusing to drink and declined food all day. The progress notes on that same day indicated that the physician requested to be informed if the resident continued to refuse to eat.
Review of the food intake consumption record and the progress notes on the third day revealed that the resident refused to eat and drink in the morning and the afternoon until he/she was transferred to the hospital on that evening for possible dehydration.

Interview with an identified registered staff and DOC confirmed that the home did not ensure that the family members participated fully in making any decision concerning resident care when resident #1 refused to eat for three days, prior to the hospital transfer. [s. 3. (1) 11. iii.]

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 substitute decision-maker participated fully in making any decision concerning any aspect of his or her care, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Interview with resident #1's family member revealed that he/she was admitted to the hospital on an identified date with a severe mouth infection.
Record review of the hospital notes on an identified date indicated that sores were noted and foul odor was coming from the resident's mouth and his/her mouth was very dry and brown in color.

Record review of the written plan of care revised on an identified date indicated to rinse the dentures and give them to the resident in the morning and to soak the dentures in a cleaning solution in the evening. Record review indicated that the plan of care does not address how to clean the resident's oral cavity based on this resident's individual requirements.

Review of the report entitled "ADL-Oral Care" for twenty-seven days prior the resident's hospital transfer, indicated that the oral care was provided twice a day to resident #1.

Interview with identified personal support workers revealed that resident #1's mouth was

cleaned with an oral cleaning swab and was rinsed with mouth wash.
Interview with an identified registered staff and ADOC confirmed that the resident's written plan of care did not set out clear directions on how to clean the resident's mouth to staff and others who were providing direct care to the resident. s. 6. (1) (c)]

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

Review of the reconciliation admission order form on an identified date indicated to obtain a laboratory test for resident #1.

Review of the progress notes indicated that the resident was transferred to the hospital on an identified date. Review of the progress notes from an identified date revealed that a family member informed an identified registered staff that the resident had been diagnosed with a specific infection and was inquiring why the identified laboratory test was not done.

Review of the resident's records and interview with the DOC confirmed that the laboratory test was not taken as ordered by the physician since his/her first re-admission on an identified date. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Review of the reconciliation admission order form and resident #1's written plan of care on an identified date, indicated to complete a continence care procedure weekly.
Review of the progress notes and interview with an identified registered staff revealed that the continence care procedure was completed on an identified date.
Interview with identified registered staff revealed that the continence care procedure was completed as ordered once a week for three identified dates, but the provision of care set out in the plan of care was not documented.

Interview with the ADOC confirmed that the provision of the care set out in the plan of care was not documented in both the treatment administration record or in the progress notes on the three identified dates.

Record review of the home's Continence Care procedure indicated that the purpose for continence care procedure was to decrease the risk of urinary infection. The registered

staff will document the amount of irrigation fluid used, amount returned as drainage, characteristics of output and urine drainage and the resident's tolerance to the procedure.

Interview with the DOC confirmed to home's expectation is that the registered staff would sign off on the treatment administration record (ETAR) for the continence care procedure and document in the progress notes. [s. 6. (9) 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person as far in advance of the discharge as possible.

Interview with the substitute decision maker (SDM) revealed that the home did not notify them in advance that resident #1 would be discharged from the home if the medical absence exceeds thirty days.
Record review indicated that the resident was transferred to the hospital on November 21, 2014.

Review of the medical absence record and interview with the administrative manager indicated the identified date was the last day that the resident could be on a medical leave.

Review of the progress notes for the identified date indicated that the family member inquired if an extension could be made and was informed that no extension could be made as it was the last day for the medical leave.
Interview with the administrator and the DOC confirmed that the resident's family was not notified in advance that the medical leave should not exceed thirty days. [s. 148. (1) (a)]

Issued on this 24th day of April, 2015

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

Original report signed by the inspector.