**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 26, 2014 | 2014_188168_0021 | H-001249-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

**Long-Term Care Home/Foyer de soins de longue durée**

DEER PARK VILLA
150 CENTRAL AVENUE, GRIMSBY, ON, L3M-4Z3

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

LISA VINK (168), DIANNE BARSEVICH (581), JENNIFER ROBERTS (582)

## 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 18, 19, 22, 23, 24 and 25, 2014.**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Resident Assessment Instrument (RAI) Coordinator, Human Resources Consultant, Building Services Supervisor, Registered Staff, Personal Support Workers (PSW), Dietary Aides (DA), Housekeeper, families and residents.**

**During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including and not limited to meeting minutes, policy and procedures, menus and clinical health records.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Continence Care and Bowel Management**
**Dining Observation**
**Family Council**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

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**Findings/Faits saillants :**

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A. Resident #112 was observed sitting in a tilt wheelchair on September 18, 22, and 24, 2014. Review of the clinical record indicated that the resident received a tilt wheelchair in 2013. There was no assessment completed to determine the reason for the use of the device, nor any documented approvals for its use. The RAI Coordinator confirmed that the resident was not assessed to determine if the tilt wheelchair was used as a PASD or a restraint nor did they have a documented approval for the device in place.
B. Resident #102 was observed sitting in a tilted chair with a seat belt fastened on September 18, 22, and 24, 2014. Review of the clinical record indicated that the resident was provided the chair in 2014. There was no assessment completed to determine the reason for the use of the device, nor any documented consent or approvals for its use. The RAI Coordinator confirmed that the resident was not assessed to determine if the tilt chair was used as a PASD or a restraint nor did they have a documented consent or approval for the device in place. [s. 33. (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 ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living is included in a resident’s plan of care only if all of the following are satisfied:***
***1. Alternatives to the use of a PASD are considered and tried where appropriate.***
***3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations. and***
***4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.***

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**WN #2: 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:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that foods and fluids were served at a temperature that was both safe and palatable to the residents.

The home's food temperature log indicated that hot foods must be served at a minimum of 60 degrees Celsius (C) and cold foods at a maximum of five degree C.
Three residents identified concerns with the temperature of food being served at meal times.
Residents' Council Meeting Minutes of February 2014, included a concern related to food temperatures.
On September 24, 2014, at the breakfast meal food was probed at the time that the last resident was served their meal. The temperatures of regular textured food items were identified as: sausage 45 degrees C, waffles 41.7 degrees C and whole wheat toast at 45.6 degrees C, all below the minimum temperature range as identified in the home's log. [s. 73. (1) 6.]

***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 foods and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

The home's policy "Infection Prevention and Control, QC04-002, last reviewed September 11, 2012", identified when staff were to wash their hands which included: "after every resident contact", "after handling resident belongings", and "after handing any contaminated items".

A. During the noon meal service on September 18, 2014, three PSW staff did not follow the home's "Infection Prevention and Control" policy. The staff were observed on numerous occasions to remove soiled dishes from the tables and then serve other food items to residents or assist residents with feeding activities without completing hand hygiene in between the tasks.
B. During the afternoon nourishment pass on September 18, 2014, a PSW did not follow the home's "Infection Prevention and Control" policy. The staff member was observed distributing snacks and beverages to residents in their rooms on the first floor while also removing soiled dishes from the bedrooms. The staff member did not complete hand hygiene between contact with clean and soiled items during the period of time observed. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #4: 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. (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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #113 was observed to use a seat belt and tilt wheelchair as a PASD as confirmed during resident and staff interview and a review of the physician's order and signed consent. The plan of care noted the use of PASD's for this resident however; did not include the use of the tilt wheelchair. Interview with registered staff confirmed that the tilt wheelchair was planned care for the resident and should be included in the plan. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #113 demonstrated responsive behaviours. The Minimum Data Set (MDS) assessment completed April 27, 2014, identified that the resident demonstrated four behavioural symptoms during a specified time period, one of which was not easily altered. The MDS assessment completed July 6, 2014, identified that the resident now only demonstrated one behavioural symptom, which was easily altered. This assessment also noted that there was no change in behavioural symptoms in the past 90 days. Interview with registered staff confirmed that the assessment completed on July 6, 2014, was not consistent with the previous assessment, when it noted that there was no change in status and that the behavioural symptoms should have been coded as an improvement.
B. Resident #104 was known to demonstrate responsive behaviours. A review of the MDS assessment completed December 8, 2013, identified that the resident displayed only one behavioural symptom in the past seven days. The MDS assessment completed February 9, 2014, noted that the resident demonstrated four behavioural symptoms, two of which were not easily altered, but failed to identify that the behavioural status had changed over the past 90 days. Interview with the RAI Coordinator confirmed that the residents behavioural status had deteriorated. [s. 6. (4) (a)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure there was a written record of each annual evaluation of the staffing plan which included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Administrator provided a written copy of the annual evaluation of the staffing plan for 2013. A review of the document provided statistical information however; did not include the date of the evaluation, nor a summary of the changes made nor when they were implemented, as confirmed by the Administrator. [s. 31. (4)]

**WN #6: 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 failed to ensure that all planned menu items were offered and available at each meal.

On September 24, 2014, during the breakfast meal on the first floor a sign noted that bananas would not be served as planned on the menu. There was no substitution for the bananas identified on the menu. Bananas were not offered or available to residents during the meal and interview with the DA confirmed that the planned menu item was not available nor was a substitution offered. [s. 71. (4)]

**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. (2) The food production system must, at a minimum, provide for,**
**(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all menu substitutions were communicated to residents and staff.

A. During the noon meal on September 18, 2014, the daily menu posted on the first floor noted cream of tomato soup, and the weekly menu posted in the same area noted cream of potato soup. Cream of tomato soup was served to residents. Interview with DA confirmed that the weekly menu posted for residents was not updated to reflect this substitution.
B. During the noon meal on September 23, 2014, the daily posted menu on the first floor noted broccoli florets and the weekly menu posted in the same area noted squash. Squash was served to the residents. Interview with DA identified that she was not aware that broccoli florets was on the daily menu and that it was not available. [s. 72. (2) (f)]

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

On September 19, 22, and 23, 2014, offensive and lingering urine odours were noted in the bathing suite on the second floor. Staff verified that this area was cleaned on a daily basis. On September 23, 2014, a PSW commented on the presence of the urine odours in the room.
The Administrator confirmed that the home had not developed a policy to address lingering and offensive odours. [s. 87. (2) (d)]

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**Issued on this 26th day of September, 2014**

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