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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 16, 2017	2016_434631_0018	030571-16	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

KERRY ABBOTT (631), IRENE SCHMIDT (510a)

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): October 21, 2016, November 23, 24, 25, 28, 29, 30, 2016, and December 1, 2, 6, 7, 8, 9, 2016.

During the course of this inspection, the following additional inspections were conducted: Critical Incident (CI) #016275-15 related to prevention of abuse and neglect, CI #015800-16, related to prevention of abuse and neglect, CI#020164-16, related to fall with injury, CI #028866-16, related to prevention of abuse and neglect, and complaint #021643-16, related to care not provided. Kelly Chuckry, Inspector #611 attended this RQI and contributed to this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Food Service Manager, rehabilitation staff, physiotherapy staff, registered staff, personal support workers (PSW), residents and families. During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A review of resident #301's clinical record revealed that on:
1. An identified date in 2016, the resident was using their mobility device in an unsafe manner. This was identified as a risk to the resident's safety.
2. Two days later, the resident was provided a wheelchair, for independent ambulation.
3. Twenty-five (25) days later, the document the home referred to as the care plan was updated to include that the resident would continue to propel their own wheelchair.
The above was confirmed by the Director of Resident Care (DRC). The plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. A review of the resident #008's clinical record indicated that the resident suffered from a fall on an identified date in 2016, which resulted in injury to the resident. Prior to the incident, the resident's plan of care indicated that the resident utilized the aid of a mobility device for toileting, transferring, dressing, mobility and bathing and safety.

A review of the resident's most recent plan of care, indicated that the resident required a mobility device for balance at all times under the focus of toileting, transferring, dressing, mobility, bathing and falls.

An interview with registered staff #102 confirmed that since the resident's fall and subsequent injury the resident no longer used their mobility device for any activities of daily living (ADL's). Staff #102 confirmed that the resident required two person assistance with a mechanical lift for ADL's such as toileting, transferring, dressing, mobility, bathing and did not utilize their mobility device for safety.

An interview with the Administrator confirmed that the resident's focus for toileting, transferring, dressing, mobility, bathing and falls were not revised when the resident's care needs changed. [s. 6. (10) (b)]

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 residents are reassessed and the plan of care is reviewed and revised at least every six (6) months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

On an identified date in 2016, resident #301 was observed sitting in their wheelchair, in the hall. There was no one nearby. Suddenly the chair back released, jolting the resident backward, (into a full reclining position), unexpectedly. The inspector approached at the same time as a PSW staff # 102. The resident did not appear concerned by the sudden repositioning. PSW #102 notified the Registered Nurse (RN) who responded, sat the resident up and moved them upstairs to obtain another wheelchair. Staff #102 confirmed the chair was broken.

On an identified date in 2016, rehabilitation staff #103, confirmed that, subsequent to the incident, the chair had been sent for repair and the tilt function, was repaired. The above was confirmed by the DRC.

The home's equipment was not maintained in a safe condition and good state of repair. [s. 15. (2) (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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home reported an incident that took place on an identified date in 2016, in which resident #001alleged that PSW staff #109 purposefully grabbed an identified extremity of the resident's, causing pain and injury.

The home conducted an investigation that resulted in disciplinary action against the employee. A review of the home's Abuse and Neglect-Zero Tolerance policy, dated July 7, 1994, and revised July 20, 2014, defined physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain". An interview with the Administrator confirmed that the home failed to protect the resident from abuse by anyone in the home. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

On an identified date in 2015, PSW staff #105 was verbally abusive to resident #200. This verbal abuse occurred while providing care to resident #200 who was exhibiting responsive behaviours, calling the resident an offensive name.

On the same day, staff #105 was verbally abusive to resident #004 and spoke to this resident in a belittling and offensive manner.

Both incidences of alleged verbal abuse were reported to the Ministry of Health and Long Term Care on an identified date in 2015, four (4) days after the alleged incidences.

The home has a policy in place entitled Abuse and Neglect-Zero Tolerance RR00-01 revised on July 30, 2014. This policy outlined that the SDM, if any, or any other person specified by the resident must be notified immediately upon becoming aware of the incident that has occurred. It further indicated that the Administrator or DRC will notify the Ministry of Health and Long Term Care immediately.

An interview conducted with the DRC confirmed that the home did not follow the above noted policy. The home did not immediately notify the Ministry of Health and Long Term Care of the incidences of alleged verbal abuse, and did not notify resident #200's SDM of the alleged incident as indicated in the policy. [s. 20. (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 policy in place to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #5: 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 failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to, 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.

An initial tour of the home was conducted on an identified date in 2016. Part of this tour included the review of posting of information.

The home had posted the required information, including copies of inspection reports from the past two years. Upon review of these inspection reports, the home had posted licensee copies of two inspection reports as opposed to the public copy of these reports. These included inspection #2015_1888168_0020, which was an inspection entitled "other", and #2015_205129_0005, which was a Resident Quality Inspection.

The Resident Quality Inspection contained personal health information of residents in the home, resulting in the home not protecting this resident right to have their personal health information kept confidential.

An interview conducted with the Administrator confirmed that the licensee copies of the reports were inadvertently posted in the home. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A Residents' Council meeting was held on an identified date in 2016 and the minutes from this meeting reflected two areas of concern. One concern was that supper arrives fifteen (15) to seventeen (17) minutes late, and the second was that snacks were not being provided in the evening. A response was not provided in writing to Residents' Council with respect to these two concerns.

Another Residents' Council meeting was held on an identified date in 2016, and the minutes from this meeting reflected two areas of concern. One concern was that vegetables were not cooked properly, and food was arriving late to the unit for the start of the meal service. A Resident Council Feedback Form was completed and signed four days after the meeting however, this feedback form was in fact signed and dated on an identified date two months after the meeting.This form was signed by the Food Service Manager, and was confirmed to have been signed and backdated to four days after the meeting date. This information was not provided within ten (10) days of receiving the Residents' Council concern.

The president of Residents' Council confirmed that she is not aware that responses were provided in writing within ten (10) days. An interview conducted with the DRC and the Food Service Manager further confirmed that responses were not provided in writing within ten (10) days of receiving the concern. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that semi-annual meetings, to advise residents' families and persons of importance to residents of their right to establish a Family Council, were convened.

The Administrator confirmed that there was no Family Council at the home and provided a notice, dated on an identified date in 2016, of communication directed to Deer Park Family members, advising family members that Deer Park did not currently have a Family council and invited any family members who were interested in establishing a family council to contact the Administrator. The Administrator advised that no family members have approached the home to establish a council. The Administrator confirmed that they have not convened semi-annual meetings in 2016 to advise family members of the right to establish a family council, as required under the Act. [s. 59. (7) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs include, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

During stage one (1) of the Resident Quality Inspection, a review of resident heights took place as part of the data collection process. It was noted that three (3) out of eleven (11) residents, or twenty-seven (27) percent of the sample did not have a height measured and recorded annually.

An interview with the Director of Resident Care and Services confirmed that an annual height was not measured and recorded for resident #001, #004, and #007. [s. 68. (2) (e) (ii)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Residents' Council, in developing and carrying out the Satisfaction Survey, and in acting on its results.

An interview conducted with the president of Residents' Council revealed that the home did not review the Satisfaction Survey with the Council

The 2016 Residents' Council meetings took place on three identified dates in 2016. The minutes from these meetings were reviewed and they failed to provide evidence that the home sought the advice of Residents' Council in the development and carrying out the Satisfaction Survey, and in acting on its results.

An interview conducted with the Administrator further confirmed this information was not provided to the Council as indicated above. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker, (SDM) and any other person specified by the resident were notified within twelve (12) hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On an identified date in 2015, PSW staff #105 was providing care to resident #200, who was exhibiting responsive behaviours. During this interaction, staff #105 called this resident an offensive name. An investigation was initiated on an identified date in 2015, for alleged verbal abuse towards resident #200.

The licensee contacted the resident's SDM four days after the incident to notify them of the incident of alleged verbal abuse. An interview conducted with the DRC confirmed that the licensee failed to notify the SDM within twelve (12) hours upon becoming aware of this incident. [s. 97. (1) (b)]

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.