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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 28, 2017 | 2017_560632_0015 | 017630-17 | 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

YULIYA FEDOTOVA (632), KELLY CHUCKRY (611), LISA VINK (168)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): August 8, 9, 10, 11, 14, 15, 16, 17, 18, 2017**

**The following inspections were completed concurrently with the Resident Quality Inspection.**

**Critical Incident System Report:**
**029068-16 related to: Falls Prevention**
**003549-17 related to: Responsive Behaviors, Prevention of Abuse and Neglect**

**Inquiries:**
**005996-17 related to: Safe and Secure Home**

**Complaints:**
**006241-17 related to: Dignity, Choice and Privacy, Nutrition and Hydration, Skin and Wound Care**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary and Environmental Services Manager (DESM), Clinical Documentation and Informatics (CDI) Co-ordinator, Program Manager, Maintenance Co-ordinator, Dietary Aide (DA), recreation staff, residents and their families.**

**During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, reviewed documentation related to bed rails and relevant clinical records, reviewed relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, observed the provision of care, medication administration, and meal service.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**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**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| 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. 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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

1. Resident #034 was observed in an identified position in a mobility device on identified dates in August, 2017.
The resident was not observed to make any attempts to move from the device or reposition themself.
Interview with staff #143 and #113 confirmed that the resident was in a reclined position, that this was an assessed need for comfort and positioning only and not a restraint or Personal Assistance Services Device (PASD).
An interview with Staff # 143 on identified dates in August, 2017, indicated that the resident did not move and did not attempt to get up from the device. The plan of care did not address all aspects of positioning in the mobility device and did not address the position observed. Interview with the Administrator confirmed that the plan of care should have included the identified positioning for comfort and that this intervention had since been added under the focus statement for "mobility". (168)

2. On an identified date in August, 2017, resident #031 was observed seated in an identified position in a mobility device. On identified dates in August, 2017, staff #123 was interviewed and indicated that the observed position was for comfort. A review of the plan of care for resident #031 (last updated on July 20, 2017) stated that the resident was totally dependent on one staff for assistance with mobility. The resident's plan of care did not contain information about the use of mobility device or its observed positioning for comfort. On an identified date in August, 2017, CDI Co-ordinator confirmed that resident #031's plan of care did not contain information about the use of mobility device or the positioning observed for comfort. A review of the most recent PASD assessment, called PASD Evaluation, indicated that the mobility device, which had previously been considered a PASD, was discontinued on an identified date in October, 2016, for the resident, and was no longer classified as a PASD. The Administrator confirmed that the records in resident #031‘s plan of care were not based on an assessment of the resident's needs and preferences. (632)

3. On identified dates in August, 2107, resident #037 was observed seated in an identified position in a mobility device. On an identified date in August, 2017, staff #113 was interviewed and indicated that the positioning observed was for comfort. A review of the plan of care for resident #037 (last updated on June 27, 2017) stated that the resident was totally dependent on one staff for assistance with mobility. The resident's plan of care did not contain information about the use of the device or positioning for comfort. On an identified date in August, 2017, CDI Co-ordinator confirmed that resident #037's plan of care did not contain information about the use of device or positioning for

comfort. A review of the most recent PASD assessment, called PASD Evaluation, indicated that the device, which had previously been considered a PASD, was discontinued and was no longer classified as a PASD from an identified date in September, 2016. The resident required to have their position changed, while in the device, in accordance to Regional policy without need of a PASD. The Administrator confirmed that the records in resident #037's plan of care were not based on an assessment of the resident's needs and preferences. (632) [s. 6. (2)]

***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 and ensuring that the plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.***

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**WN #2: 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 failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.
Long-Term Care Homes Act, 2007 section 84 requires the licensees to have continuous quality improvement activities, to develop and implement a quality improvement and

utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

The home's policy and procedure "Risk Management Program, RKM00-016", last reviewed October 15, 2012, outlined the policy related to risk management, the background and definition. Interview with the Administrator identified that the "Region of Niagara Quick Reference", reviewed October 2016, provided additional direction to staff regarding the program and outlined "Risk Management must be completed for each resident when an incident occurs", "select the type/nature on the incident", "complete the assessment form attached (contains all the information that is in the risk management portal)", "SPN note (structured note will pull into the Resident chart), there is no need to write another progress note with all of this information, follow up and document for 48 hours". The Administrator also communicated that the home had a draft procedure, which was created and will be circulated to provide additional clarification to staff related to Risk Management in Point Click Care (PCC), which details direction for registered staff to follow for incidents including responding to medical needs and providing support, notification of the relevant parties, completion of the Risk Management Module in PCC, completion of all other required documentation including progress notes and assessments. A review of the Risk Management Module includes: a description of the incident by staff and the resident, description of action taken, any injuries sustained, pain assessment, change in level of consciousness or mobility, any witnesses, notification to additional individuals including management of the home, family, the physician, Ministry of Health and Long-Term Care (MOHLTC), etc. and additional tasks completed including initiate or update the care plan.

A. A review of the progress notes for resident #017 identified that they were involved in an incident with a co-resident in an identified date in August 2016. Interview with the Administrator identified the co-resident to be resident #036, which was supported during an interview with recreation staff #401 and the former DOC. A review of the clinical record for resident #017 included a progress note regarding the incident as well as an immediate follow up action by the DOC. There was no evidence of a Risk Management Module in PCC, for resident #017, as confirmed during a review of the electronic documentation by the DOC and staff #143. A review of the clinical record for resident #036 did not include any documentation of the incident, notification of required parties or assessments/follow up monitoring, nor a Risk Management module, as confirmed by the DOC following a review of the electronic documentation and progress notes. Interview with the Administrator, DOC and staff #143 each verified the need to document all

incidents of this type for both resident's in the clinical record and in Risk Management, notify the substitute decision makers (SDMs), and complete and record follow up assessments/monitoring for a period of time post incident. Interview with the former DOC could not recall if the family of resident #036 was notified; however, identified it was the role of registered staff to complete the Risk Management module.

B. A review of the progress notes for resident #017 identified that they were involved in an incident with a co-resident in August 2016. Interview with the Administrator identified the co-resident to be resident #020, which was supported during an interview with the former DOC and staff #400, who documented the incident. A review of the clinical record for resident #017 included a progress note regarding the incident as well as immediate follow up action by the DOC. There was no evidence of a Risk Management Module in PCC, for resident #017, as confirmed during a review of the electronic documentation by the DOC and staff #143. Staff #400 verified that a Risk Management module was not completed, nor could they recall if family were notified. A review of the clinical record for resident #020 included a progress note regarding the incident as well as immediate follow up action by the DOC for co-resident #017. There was no documentation, in the record of resident #020, for notification of required parties or assessments/follow up monitoring, nor a Risk Management module, as confirmed by the DOC following a review of the electronic documentation and progress notes. Interview with staff #143 verified that a Risk Management module was not completed for the incident. Interview with the Administrator and DOC each verified the need to document all incidents of this type in Risk Management, notify the substitute decision makers (SDMs) and complete and record follow up assessments/monitoring for a period of time post incident. Interview with the former DOC could not recall if the family of resident #020 was notified; however, identified it was the role of registered staff to complete the Risk Management module.

C. Critical Incident report M611-000001-17, identified an alleged incident between resident #017 and co-resident #030 in February 2017, which was detailed in progress notes in both residents clinical records. The progress notes for each resident identified that the SDMs were notified, follow up assessment and monitoring as well as additional actions taken. There was no evidence of a Risk Management Module, in PCC, for resident #017 or #030 as confirmed during a review of the electronic documentation by the DOC and staff #143. Interview with the Administrator, DOC and staff #143 each verified the need to document all incidents of this type for both resident's in Risk Management. [s. 8. (1) (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 and ensuring that where the Act or this Regulation required 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, is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

1. According to the clinical records, resident #017 was involved in an incident with a co-resident in August 2016.
The co-resident was identified by the former DRC, Administrator and staff #401 to be resident #036.
A review of the clinical record for resident #036 did not include documentation of the incident nor any assessment of the resident or interventions put in place.
Interview with the former DRC and staff #401 verified that actions were taken post incident in an effort to meet the resident #036's needs.
Interview with the Administrator and DRC verified that there was no documentation of the incident, assessments or interventions in the clinical record of resident #036 as required.

Please note: this finding of non-compliance was identified during CI inspection log #003549-17. [s. 30. (2)]

2. A review of a complaint submitted by the family to the MOHLTC indicated that staff were inconsistent in application of skin treatment for resident #001, who had a chronic condition. The resident had a chronic condition on an identified area that required some treatment in the morning and in the evening as it was ordered on an identified date in July, 2016. An interview with resident #001 and their POA indicated that the treatments were not applied consistently. A review of the resident's clinical records indicated that treatments were not recorded by the registered staff on identified dates in July and August, 2017, which was confirmed by staff #143 on an identified date in August, 2017. On August 15, 2017, staff #143 indicated that they audited e-MAR records for resident #001 related to the treatments on identified dates in July and August, 2017, and staff members who did not record the cream application confirmed that they forgot to record the intervention related to the cream application for resident #001. Review of the home's Skin and Wound policy titled, "Skin and Wound Care – Program MP00-006", reviewed on June 7, 2016, under the section "Roles and Responsibilities" indicated that after each time wound care was completed, it was to be document by the registered staff on the assessment/treatment assessment on Point Click Care (PCC). On August 15, 2017, the Administrator acknowledged that actions taken with respect to a resident # 001 under a program, including interventions and the resident's responses to interventions were not documented.

Please note: this finding of non-compliance was identified during complaint inspection log #006241-17. [s. 30. (2)]

***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 and ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A review of clinical records identified that resident #017 had a known responsive behaviour towards co-residents.
This responsive behaviour was included in the plan of care prior to August 2016, when the resident demonstrated the behaviour on two separate occasions, on the same date, towards residents #036 and #020.
Interview with the former DRC identified actions taken as a result of the incidents, which included notification of the SDM of resident #017 to speak with the resident about the behaviour and offering specific material to divert the resident's attention from co-resident; however, it was unknown if this was documented in the plan of care.
A review of the plan of care did not include the interventions.
Following a review of the progress notes and plan of care the DRC confirmed that there was no documentation to support the interventions in place as identified by the former DRC.

Please note: this finding of non-compliance was identified during CI inspection log #003549-17. [s. 53. (4) (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 and ensuring that the actions taken to meet the needs of the resident with responsive behaviours include assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Review of resident #035 plan of care (last updated on an identified date in June, 2017) indicated that the resident required extensive assistance by two staff with toileting. On an identified date in August, 2017, extensive assistance was provided by one staff #118 for the resident with toileting without incident or pain, which was observed by the Inspector # 632. On August 10, 2017, staff #118 indicated in an interview that two staff were to provide the assistance with toileting for resident #035. On August 11, 2017, the home's Administrator acknowledged that staff did not use safe transferring and positioning techniques when assisting resident #035. [s. 36.]

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

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**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**

**Issued on this 6th day of October, 2017**

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

**Original report signed by the inspector.**