Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2021	2021_905683_0022	019659-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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 BOS (683), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): December 8-10 and 13-14, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nutritional and Environmental Manager, Campus Program Manager, Scheduling Clerk, Maintenance Supervisor, Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary staff, housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, infection prevention and control (IPAC) practices, meal service, medication administration, and reviewed clinical records, relevant policies and procedures, meeting minutes and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 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	Légende 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. (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. (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 has failed to ensure that resident rest routines were followed, as per their plans of care.

A) A resident's plan of care indicated that they were to have a rest period at a specified time of day.

During the resident's rest period, they were not observed to be in bed. Two Personal Support Workers (PSWs) reported that they referred to Point of Care (POC) tasks to identify resident rest periods. They stated that the resident did not have a task for the identified rest period, so they were not assisted to bed.

The Director of Resident Care (DRC) acknowledged that the resident's rest routine was not followed as per their plan of care.

Sources: Resident observations; a resident's clinical record; interviews with PSWs and the DRC.

B) A resident's plan of care indicated that they were to have a rest period at a specified time of day.

During the resident's rest period, they were not observed to be in bed, and instead, were observed sleeping in their mobility device in a resident common area. Two PSWs reported that they referred to POC tasks to identify resident rest periods. They stated that the resident did not have a task for the identified rest period, so they were not

assisted to bed.

The DRC acknowledged that the resident's rest routine was not followed as per their plan of care.

Sources: Resident observations; a resident's clinical record; interviews with PSWs and the DRC.

C) A resident's plan of care indicated that they preferred to rest at a specified time of day and stated that they may request an alternative time to retire to bed depending on their mood or choice.

Staff were notified that a resident wished to be transferred to bed to rest. A PSW stated that they would let the oncoming staff know. Just under two and a half hours later, the resident still was not transferred to bed to rest. A PSW and RPN acknowledged they were not aware that the resident requested to go to bed.

The DRC acknowledged that the resident should have been transferred to bed as per their request and as per their plan of care.

Sources: Resident observations; a resident's clinical record; interviews with a PSW, RPN and the DRC. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care for a resident was revised when changes in care needs related to oral care was no longer necessary.

The plan of care for a resident noted that they required assistance with oral care and that they participated in part of the activity. The POC records for the task of oral care, noted that mouth care was to be completed with a specified device.

A PSW identified that the device was not available in the home and that mouth care was to be completed by staff as the resident was not able to participate in the activity.

The DRC identified that there was a recent change in how oral care was provided to the resident and that staff were to use the device to complete care twice a day. The DRC confirmed that the resident no longer participated in the activity and that the plan of care was not revised with a change in care needs.

Failure to ensure that the plan of care was revised with changes in care needs had the potential to result in unmet care related to oral hygiene of the resident.

Sources: Plan of care and POC records for a resident; interview with a PSW and other staff. [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 the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week unless contraindicated by a medical condition.

A) The bath assignment identified that a resident was to be bathed twice a week, which was confirmed by the resident.
POC records identified that the activity of bathing did not occur on one occasion, as recorded by a PSW.
The PSW confirmed that on occasions when they worked with less than the planned PSW complement, bathing was not always completed as required.
It was confirmed that the home worked below their planned PSW staffing complement on the date of the missed bath.

Failure to complete bathing at the frequency of twice a week had the potential to

negatively impact the resident's hygiene.

Sources: Review of POC records; observations of a resident and discussion with a PSW and other staff.

B) The bath assignment identified that a resident was to be bathed twice a week.
POC records identified that the activity of bathing did not occur on one occasion, as recorded by a PSW.
The PSW confirmed that on occasions when they worked with less than the planned PSW complement, bathing was not always completed as required.
It was confirmed that the home worked below their planned PSW staffing complement on the date of the missed bath.

Failure to complete bathing at the frequency of twice a week had the potential to negatively impact the resident's hygiene.

Sources: Review of POC records; observations of a resident and discussion with a PSW and other staff.

C) The bath assignment identified that a resident was to be bathed twice a week.
POC records identified that the activity of bathing did not occur on two occasions, as recorded by PSW staff.
The PSWs confirmed that on occasions when they worked with less than the planned PSW complement, bathing was not always completed as required.
It was confirmed that the home worked below their planned PSW staffing complement on the identified dates.

Failure to complete bathing at the frequency of twice a week had the potential to negatively impact the resident's hygiene.

Sources: Review of POC records; observations of a resident and discussion with PSWs and other staff. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that residents received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

A) According to the plan of care, a resident required assistance with oral care and staff were to provide the care twice a day and as needed.

Observation of the resident's toothbrushes on two occasions noted that the bristles were dry.

A PSW who assisted with morning care verified that oral care was not provided on the identified dates.

Failure to ensure that oral care was completed at the frequency of twice a day had the potential to negatively impact the resident's oral health/hygiene.

Sources: Plan of care for a resident; resident observations and interview with a PSW and other staff.

B) According to the plan of care, a resident required assistance with oral care and staff were to provide the care twice a day and as needed.

Observation of the resident's toothbrushes on two occasions noted that the bristles were dry.

A PSW who assisted with morning care verified that oral care was not provided.

Failure to ensure that oral care was completed at the frequency of twice a day had the potential to negatively impact the resident's oral health/hygiene.

Sources: Plan of care for a resident; resident observations and interview with a PSW and other staff.

C) According to the plan of care, a resident required assistance with oral care and staff were to provide the care twice a day and as needed.

Observation of the resident's toothbrushes on three occasions noted that the bristles were dry.

A PSW who assisted with morning care verified that oral care was not provided.

Failure to ensure that oral care was completed at the frequency of twice a day had the potential to negatively impact the resident's oral health/hygiene.

Sources: Plan of care for a resident; resident observations and interview with a PSW and other staff. [s. 34. (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 to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that oral care supplies were readily available to meet the nursing and personal care needs of a resident.

Staff were to use a device to complete oral care twice a day for a resident.
A PSW reported that the home did not have the device available for use.
Observations of the resident's room, the clean utility rooms on both floors and the nursing storage area did not locate any of the devices, as confirmed by the DRC.
The home did not have the supplies available to meet the oral care needs of the resident.

Failure to provide oral care supplies had the potential to negatively impact the resident's oral hygiene/health.

Sources: Plan of care and POC records and observation of a resident’s room; observations of nursing storage areas and interview with the DRC and other staff. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was turned and repositioned every two hours.

A resident's plan of care indicated that they were to be turned and repositioned every two hours during the day. They were observed for over two and a half hours and they were not turned or repositioned by staff.

The DRC acknowledged that staff should have turned and repositioned the resident during the observation period.

A resident was placed at risk of skin breakdown when they were not turned and repositioned every two hours.

Sources: Resident observations; a resident's clinical record; interview with the DRC. [s. 50. (2) (d)]

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 any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

The home's Personal Protective Equipment (PPE) policy directed staff to remove their gloves and gown and perform hand hygiene, and remove their eye protection and mask and perform hand hygiene again, upon exiting a room where contact/droplet precautions were required.

A resident required contact and droplet precautions.

A Registered Nurse (RN) was observed providing care to the resident and upon exiting the room, they removed their gloves and gown, performed hand hygiene and removed their face shield, but they did not remove their surgical mask.

The RN stated that they did not remove their surgical mask because they had a face shield on.

The DRC acknowledged that the RN should have removed their surgical mask while exiting the resident's room, as per their PPE policy.

There was an increased risk of infectious disease transmission when the RN failed to remove their surgical mask upon exiting the resident's room.

Sources: IPAC observations; the home's PPE policy; a resident's clinical record; interviews with a RN and the DRC. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was on at all times for a resident.

The communication and response system at the bedside for a resident was connected to a bed alarm, and the inspector was not able to activate the system.

A maintenance staff member demonstrated that the communication and response system was dependent on the bed alarm to function as it was connected to the alarm, not directly to the wall. They confirmed that when tested, the system did not work and was not on. The batteries in the bed alarm were replaced at which time both the bed alarm and the communication and response system were operational.
The communication and response system was not independent of the bed alarm and the system was not on when the bed alarm required replacement batteries.

Failure to ensure that the resident-staff communication and response system was on at all times had the potential to prevent the resident or staff from alerting others that they were in need of assistance.

Sources: Observations and testing of the communication and response system and interviews with staff. [s. 17. (1) (b)]

Issued on this 22nd day of December, 2021

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

Original report signed by the inspector.