Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 5, 2023
Inspection Number: 2023-1606-0002
Inspection Type: Proactive Compliance Inspection
Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: Deer Park Villa, Grimsby

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2023.12.07 10:09:17 -05'00'

Additional Inspector(s)
Barbara Grohmann (720920)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 16-17, 20-24, 27-28, 2023.

The following intake(s) were inspected:

- Intake: #00101494 was a Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A resident's care plan identified they needed an intervention during meals. During a meal observation, the intervention was not present. Additional observations showed that the intervention was never used at meals.

The Nutrition and Environmental Manager confirmed that the intervention was no longer required for the resident. They stated that the resident's care plan would be updated.

The intervention was removed from their care plan on an identified date.

Sources: A resident's clinical records; observations; interview with the Nutrition and Environmental Manager.
[720920]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that the written policy developed for the destruction and disposal of Narcotics and controlled substances in the home, was in compliance with all applicable requirements under the Act.

Rationale and Summary
In accordance with Ontario Regulation 246/22 s. 11 (1) a, the licensee was required to ensure that where the Act or the Regulation required the licensee of a long-term

care home to have, or put in place a policy, that the policy was in compliance with all applicable requirements under the Act.

O/Reg. 246/22 s. 148 (3) (a), stated:
Drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) at least one of,
(A) another member of the registered nursing staff appointed by the Director of Nursing and Personal Care,
(B) a physician,
(C) a pharmacist,
(D) a member of the College of Nurses of Ontario who is a registered nurse in the extended class,
(E) a member of the College of Pharmacists who is a pharmacy technician, or
(F) a member of the Royal College of Dental Surgeons who is a dentist in the general class; and

Specifically, the licensee did not ensure that the home's Narcotic and Controlled Substances Policy, was in compliance with the requirements, where it stated that narcotics could be destroyed by one member of the registered nursing staff appointed by the Director of Resident Care (DRC) and one other staff member appointed by the DRC.

The DRC and the administrator acknowledged that the policy did not meet the applicable requirements under the Act and immediately made the revisions to the

policy to correct the information.

Sources: Narcotics and Controlled Substances Policy, last revised July 26, 2023; Narcotics and Controlled Substances Policy, last revised November 28, 2023; interviews with the DRC and the Administrator.
[748]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, specifically following a dietary referral.

Rationale and Summary
On an identified date, a registered practical nurse (RPN) sent a dietary referral to the registered dietitian (RD) for a resident.

The RD responded to the referral two days later, and put a plan in place including a follow up in a week. However, there was no follow up documented.

The RD acknowledged that a follow up did not occur, as per the plan.

Failure to conduct a follow up assessment may have resulted in the RD being unaware if the interventions put in place for the resident, were effective, or required revisions.

Sources: A resident's clinical records, interview with the RD.
[720920]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
When reassessment, revision is required
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that the plan of care was revised when the care set out in the plan was not effective for a resident .

Rationale and Summary
A resident was identified as having a health condition and interventions were implemented.

In two quarterly assessments, the registered dietitian (RD) identified that the interventions were poorly accepted, and the resident's health condition continued. However, the RD did not make any changes to the interventions nor determine why they were poorly accepted.

The Nutrition and Environmental Manager explained that they would have expected the RD who completed the two quarterly assessments to have revised or discontinued the interventions when they were ineffective.

Failure to revise the resident's plan of care when the interventions were not effective may have resulted in the worsening of the resident's health condition.

Sources: A resident's clinical records; observations; interviews with the Nutrition and Environmental Manager, RD and other staff.
[720920]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept locked when not supervised by staff.

Rationale and Summary
The doors to the first and second floor serveries were unlocked with no staff present. The same doors were found unlocked on four other days, on multiple

occasions, with no staff present. Along with hot tables and dishwashers/sanitizers, the serveries also contained chemicals needed to clean the various types of dishware, each with a Workplace Hazardous Materials Information System (WHMIS) health hazard symbol on their label.

A dietary aide explained that the doors were typically locked at the end of the day and when staff were finished their work. They also acknowledged that the door to the second floor servery should have been locked when they left. The Nutrition and Environmental Manager stated that they expected the servery doors be closed and locked when staff were not present.

Failure to ensure that non-residential areas were locked when not supervised by staff, may have resulted in residents entering areas that could put them at risk of harm.

Sources: Observations; interviews with the Nutrition and Environmental Manager and other staff.
[720920]