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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2013	2013_188168_0030	H-002106-12, H-000243-13	Complaint

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)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 29 and 30, 2013.

This inspection was conducted with Inspector Kate Macnamara.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Resident Care, registered staff, recreation staff, residents and the Manager of Resident and Community Programs.

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

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Minimizing of Restraining

Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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).

Findings/Faits saillants :

1. The use of a PASD to assist a resident with a routine activity of living was included in a resident's plan without the following being satisfied: the use of the PASD was not 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 and the device was not consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident.

Progress notes for resident #002 indicated the use of a seat belt, while in the wheelchair, as a Personal Assistance Service Device (PASD), for two days in 2012. Staff interview and a review of the record did not locate an approval or consent for use of the device. The use of device was ordered by the physician approximately one month later, however no consent was located in the clinical record following this change in the plan of care. [s. 33. (4)]

WN #2: 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 did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with past president and current member of Residents' Council revealed that concerns were not consistently responded to in writing within ten days. Review of previous minutes identified occasions where concerns were not responded to as required specifically:
A. At the July 18, 2012, council meeting concerns were identified that were not responded to until August 2, 2012 and August 7, 2012.
B. At the October 9, 2012, council meeting concerns were identified that were not responded to until October 23, 2012.
C. At the April 9, 2013, council meeting a concern was identified regarding visiting dogs, which did not have a written response provided. [s. 57. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Resident #002 sustained a fall and was transferred to the hospital for investigation of injuries in 2012. The incident was not reported to the Director until five days later, via the critical incident (CI) system and a telephone call from the administrator, greater than one business day after the occurrence. [s. 107. (3) 4.]

Issued on this 6th day of November, 2013

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