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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Nov 14, 2016	2016_405189_0017	000816-16, 007867-16, 026248-16, 026583-16	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Deerwood Creek Care Community
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 26, 27, 28, 29, 30, 2016.

This Complaint Inspection is related to food production, plan of care, safe and secure home, transferring and positioning techniques, personal support services, nutrition and hydration.
The following intakes were inspected concurrently during this inspection: Critical Incident (CI) intake #000816-16; Complaint intakes :#026248-16, #026583-16, #007867-16.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Director of Support Services (DSS), Dietitian (RD), registered staff, personal support workers, dietary aide, cooks, family member.

During the course of the inspection, the inspector conducted a tour of the unit, observed resident and staff interactions, observed meal service, reviewed clinical health records, reviewed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System report (CIS) was submitted to the Director related to an incident that occurred during a transfer of resident #005. The CIS was as follows:

During the two person transfer the charge nurse #113's hand slipped from the hook and the other side of the bar slightly hit an identified part of resident #005's body. Resident #005 did not sustain any injury and was transferred into the bed.

Review of the written plan of care for resident #005 revealed that the resident requires mechanical lifts for transfers.

RPN #113 reported to the inspector that on an identified date, he/she was called to assist with the transfer for resident #005. RPN #113 told the inspector the PSW was standing on one side and hooked the sling onto the hoyer lift bar, and as RPN #113 hooked the sling on the other side of the bar, his/her hand slipped from the bar, and the bar went forward and hit resident #005.

Interview with RPN #113 reported that he/she did not ensure the bar was stabilized during the transfer. The Director of Care (DOC) reported that the care plan was updated to include that staff use caution during transfers to prevent striking arms, legs and hands against any sharp or hard surfaces, and to make sure resident's head and extremities are guarded during transfers. RPN #113 confirmed that he/she did not use safe transferring techniques when assisting resident #005. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On the evening of an identified date, resident #005's family member informed RN #117 that he/she found a bottle of treatment solution left on the resident's bedside table. RN #117 reported that he/she did not leave the bottle at the bedside and was unsure who left the bottle at the bedside.

During the home's investigation, it was found that on the morning of the identified date, RPN #140 was providing care to another resident. Once the care was completed, RPN #140 left the resident's room with the bottle of treatment solution in his/her hand. RPN #140 told the inspector that as he/she passed by resident #005's room, he/she stopped inside the room to check on the resident and placed the treatment bottle at the bedside. RPN #140 reported that he/she left the room and forgot to take the treatment bottle out of the room.

Interview with RN #117, RPN #140 and the DOC revealed that the treatment solution bottles are stored in the medication room on the treatment cart. Interview with RN #117, RPN #140 and the DOC confirmed that the treatment bottle left at the bedside posed a risk of harm to the residents and others, and does not provide a safe and secure environment to all residents of the home. [s. 5.]

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the plan of care for resident #005 indicated staff are to follow Special Menu for resident #005 as requested and approved by family. As per family: meal must be served following resident's special menu.

Resident #005's family member reported to the inspector that on an identified date, resident #005 was served an item not included in the specialized menu. The inspector reviewed the resident's specialized menu and plan of care which confirmed the resident was not to receive this item at lunch. Interview with the Director of Support Services revealed that an investigation was conducted in relation to the family member's concern and confirmed that the resident received the item at lunch, and that the care set out in the plan of care was not provided to resident #005 as specified. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

Review of the written plan of care for resident #005 revealed that the resident is on a modified textured diet.

Review of the progress notes revealed that on an identified date, during the lunch service, a staff member was feeding resident #005 his/her lunch. Resident #005's family member approached the staff and stated that a food item did not appear to be the correct

texture. The family member expressed his/her concern to the Executive Director and the Director of Support Services.

Interview with the Director of Support Services revealed that an investigation was conducted in relation to the family member's concern, and the cook who prepared the lunch meal received counselling that the food item needed more liquid to ensure the right consistency.

Review of the progress notes revealed that on a second identified date, during the dinner service, resident #005's family member approached the RPN and stated that part of the resident's meal was not the correct texture. The RPN went to observe the resident's meal and noted that a food item was not the correct texture. The RPN contacted the Director of Support Services to address the issue.

Interview with the Director of Support Services revealed that on the identified date, the resident was served a food item that was not the correct texture but was consistent of another texture. The Director of Support Services stated that the home investigated the incident and found the food item required more liquid and blending to ensure the correct consistency and that the cook who prepared the meal was disciplined for not serving the correct texture.

Review of the progress notes revealed that on a third identified date, during the dinner service, resident #005's family member approached the RPN and stated that part of the resident's meal was not the correct texture. The RPN observed that meal was not the correct texture but more liquid. The family requested to speak to the cook #123 and to notify the Director of Support Services about the incident.

Interview with cook #123 revealed that on the identified date, he/she prepared the food item of the correct texture for the resident, placed it on a specialized plated and covered it with saran wrap to steam. The cook stated that during the steaming process, the saran wrap had a small hole in it and condensation got into the plate, which changed the consistency of the food item to more liquid. The Director of Support Services revealed that the cook received a verbal warning regarding the incident.

Interview with the Director of Support Services revealed that on the above identified dates, resident #005 did not receive the correct texture as per plan of care, and that the dietary staff did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve appearance and food quality. [s.

72. (3) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Food and fluids being served at a temperature that is both safe and palatable to the residents.

On an identified date, resident #005 was served starches during the lunch service. Review of the progress notes revealed that resident #005's family member informed the Director of Support Services that there was no meat served for lunch. The Director of Support Services exchanged the lunch plate and the dietary staff provided the resident a new lunch plate with meat. When the family member tasted the meat he/she reported that the meat was cold. When the Director of Support Services tested the temperature of the meat, the temperature of the meat recorded as 45 degrees Celsius.

Interview with the Director of Support Services revealed on the identified date, prior to serving the meat to the resident, the dietary staff had taken the temperature of the meat and it was recorded as 60 degrees Celsius. The Director of Support Services told the inspector that hot foods should be above 60 degrees Celsius prior to point of service. The inspector and the Director of Support Services reviewed the dietary temperature log for the identified date lunch service, and there was no documentation of the recorded temperature for the meat. During record review of the temperature log for an identified month, the inspector found five days where there was no record of food temperatures taken prior to point of service for the identified unit.

The home's policy titled "Pleasurable Dining Responsibilities & Dining Room Services Process", revised January 2015, directs the dietary staff to record food temperatures and follow corrective actions ensuring hot foods are hot and cold foods are cold.

Interview with the Director of Support Services confirmed the temperature records were missing on the identified dates. The meat served to the resident at 45 degrees was not safe or palatable. [s. 73. (1) 6.]

Issued on this 22nd day of November, 2016

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

Original report signed by the inspector.