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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, 2016	2016_356618_0020	028404-16	Resident Quality Inspection

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

CECILIA FULTON (618), NICOLE RANGER (189), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 21, 22, 23, 26, 27, 28, 29, 30, and October 3, 4, 7, and 11, 2016.

The following Critical Incidents were inspected:

Related to Transferring and Positioning: Log(s) # 028628-15, 014381-15.
Related to Continence Management: Log(s) # 014760-16, 001059-16, 00128-15.
Related to Falls Prevention and Management: Log(s) # 009393-16, 027521-16.
Related to Duty to Protect: Log(s) # 005268-16.

The following Complaint intakes were inspected:

Related to Continence Management: Log(s) #007677-16,
Related to Duty to Protect: Log(s) # 026167-15.
Related to Responsive Behaviours: Log(s) # 020954-16, 021272-16.
Related to Care and Services: Log(s) # 02167-15, 025383-15.
Related to Attending Physicians and RNs: Log(s) # 032704-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC),Assistant Director of Care (A-DOC), Registered Dietitian, (RD), Resident and Family Service Coordinator (RFSC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Housekeeping (HKG), Physiotherapist (PT), Food Service Worker (FSW), Director of Resident Programs, Family Council chair and members, Resident(s) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration,
infection prevention and control practices, meal and snack service delivery, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **4 WN(s)**
- **2 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.

Review of Critical Incident Report (CIR) revealed that on an identified date, incurred an injury to an identified body part during a wheelchair transfer.

Review of the plan of care, revealed the resident used a wheelchair with foot-rests for locomotion on and off the home area.

Review of the home's "Transferring a Resident – Protocol" policy (reference #VII-G-20.20(c), (effective January 2015) revealed the PSW must ensure equipment is in good working order prior to the transfer of a resident.

Interview with PSW #109 revealed that they noticed a foot rest of resident #021's wheelchair was broken in the morning, when the resident was being transferred from bed to wheelchair. The resident placed one foot on an identified foot rest, and placed their other foot on top of that foot while being wheeled to the dining room for breakfast. PSW #109 wheel the resident to the dining room for lunch using this same technique. PSW #109 revealed that one of resident #21's feet fell off the rest and they cried out in pain while being wheeled to the dining room. PSW #109 confirmed that they were aware that the resident's foot rest was broken prior to initiating this transport.

Review of resident #021's X-ray report dated September 2015, revealed no fracture of the identified foot.

Interviews with PT #120 and DOC #112 revealed that resident #021 required both right and left foot rests be on the wheelchair to support both legs during transport. PT #120 and DOC #112 confirmed that it was not safe to wheel resident #021 with the broken foot rest. [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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products had sufficient changes to remain clean, dry and comfortable.

On January 12, 2016, a CIR was submitted to the Director which related to allegation of staff to resident neglect.

The CIR was as follows: Resident #006's Substitute Decision Maker (SDM) expressed concern that the resident's incontinent product was not changed for approximately three hours on an identified date.

Interview with resident #006's family revealed that on an identified date, they had visited the resident during the evening and left around 1800 hrs. The SDM stated that as they were leaving the unit they informed the registered staff that the resident was soiled and required to be changed. The SDM reported that they returned to the resident's room later that same evening and found the resident in worse condition than when they left. The resident's continent brief was then heavily soiled and had not been changed for three hours.

Interview with RPN #130 confirmed that upon leaving the unit at 1800 hrs, resident

#006's SDM had inform them that the resident required to be changed, and the RPN #130 also stated that the SDM reported that they had informed PSW #132 that the resident required to be changed. Interview with PSW #132 revealed that they had changed the resident at 1630 hrs, and did not go into the resident's room afterwards to change the resident as the SDM was in the room around 1800 hrs. PSW #132 confirmed that they did not go in after 1800 hrs to check if the resident required to be changed.

Interview with DOC confirmed that PSW #132 received a written warning regarding not monitoring the resident's incontinence status regularly and not providing resident with sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

2. On January 21, 2015, a CIR was submitted to the Director related to allegation of staff to resident neglect.

The CIR was as follows: The Assistant Director of Care (ADOC) received a call from evening shift RPN #138 reporting that resident #007's incontinent brief was not changed. During an evening visit the resident's family member noticed the resident's incontinent product had a lingering, offensive odour.

Interview with PSW #139 revealed that they were assigned to provide care for the resident on that day shift. PSW #139 revealed that upon arrival of her shift at 0700 hrs, they had received the resident already dressed and sitting in the wheelchair. PSW #139 revealed that they did not change the resident's incontinent product before or after breakfast and did not change the resident's incontinent product until 1430 hrs. PSW #139 reported that the resident was heavily soiled and wet.

Interview with PSW #137 revealed that they were assigned to provide care to the resident on that evening shift. PSW #137 revealed that upon arrival of their shift at 1500 hrs, resident #007 was sitting in the TV lounge. PSW #137 was assisting another resident and did not change the resident's incontinent product prior to dinner. PSW #137 reported that the resident's family member informed them that the resident was heavily soiled and wet at 1930 hrs.

Review of the plan of care dated January 13, 2015 notes that staff are to check the incontinent product at least three to six times daily and change the resident as needed to ensure that the resident is dry and comfortable. Interview with PSW #137, PSW #139 and RPN #138 confirmed that the resident did not receive sufficient changes to remain clean, dry and comfortable on this date.

Interview with DOC confirmed that PSW #137 and PSW #139 received suspensions as they had not monitored the resident's incontinence status regularly and that the resident had not received sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 resident who requires continence care products had sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home's Drug Disposal policy, #04-08-10 was complied with.

On September 28, 2016, the inspector and RPN #114, observed four tablets of an identified medication and eight tablets of another identified medication with an expiry date of July 31, 2016, in the emergency box in the medication room on an identified home area.

Review of the home's "Drug Disposal" policy (index #:04-08-10, revised July 25, 2014) indicated that expired medications are to be identified, destroyed and disposed of. The policy further indicated that drugs that are to be destroyed and disposed of are to be stored safely and securely in a pharmaceutical waste container that is separate from drugs that are available for administration to a resident.

Interviews with RPN #114 and ADOC #125, confirmed that above mentioned expired medications should have been taken out from the emergency box and placed in the pharmaceutical waste container for destruction and disposal. [s. 8. (1) (b)]

WN #4: 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. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

This inspection was initiated as a result of a complaint made by a relative of resident #033. The complaint stated that the SDM for this resident was not notified when the resident had a change in their condition.

Review of the progress notes revealed that on an identified date, resident #033's health condition deteriorated.

Interview with resident #033's SDM revealed that they did not receive any call from the home informing them about the residents deteriorating condition.

Interview with the another family member who was present at the home on this date revealed that they had not been designated by the SDM to receive information from the home and that the home should not have assumed that they did not need to keep the SDM informed about the resident's condition.

Interview with RPN #133 revealed that they thought the SDM was one of the family members present at the resident's bedside. RPN #133 revealed that they had not placed a call or informed the SDM.

Review of resident #033's progress notes did not include any documentation indicating that the SDM had been contacted.

Interview with DOC revealed that there was no direct communication with the SDM on this occasion and that staff are required to ensure that they are communicating directly with the SDM or their designate. [s. 107. (5)]

Issued on this 25th day of November, 2016

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

Original report signed by the inspector.