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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2018	2018_420643_0002	002718-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

ADAM DICKEY (643), IVY LAM (646), JUDITH HART (513), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5-9, 12-16, 20, 21, 23, 26-28, March 1 and 2, 2018.

The following critical incident intakes were inspected concurrently with the RQI: Log #024030-17, Critical Incident System report (CIS) #2837-000055-17; Log #024229-17, CIS #2837-000054-17; Log #023418-17, CIS #2837-000053-17; Log #021112-17, CIS #2837-000044-17; and Log #003486-18, CIS 2837-000008-18 related to alleged abuse;
Log #021651-17, CIS #2837-000045 related to alleged neglect and sufficient staffing;

**Log #000933-18, CIS #2837-000001-18 related to falls prevention and management;
Log #016369-17, CIS #2837-000037-17; and Log #021472-17, CIS #2837-000043-17 related to injury with unknown cause; and
Log #203425-17, CIS #2837-000051-17 related to medication management.**

**The following complaint intake was inspected concurrently with the RQI:
Log #024063-17 related to medication management.**

**The following compliance order follow-up was inspected concurrently with the RQI:
Log #024929-17 related to responsive behaviours and prevention of abuse.**

Inspector Rebecca Leung #726 attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Physiotherapy assistant, Clinical Consulting Pharmacist, Resident Relations Coordinator (RRC), Director of Resident Programs, Director of Food Services, Environmental Services Manager (ESM), scheduling coordinator, office manager, personal support workers (PSW), recreation assistant, dietary aides, housekeepers, contracted security guard, receptionists, Residents' Council and Family Council Representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' and Family Council(s) and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #002	2017_659189_0016	643
O.Reg 79/10 s. 54.	CO #001	2017_659189_0016	643

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 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 the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, for a recent medication incident which resulted in resident #022 being hospitalized. A complaint was also received by ACTIONline approximately three weeks later, from resident #022's SDM related to the same medication incident resulting in hospitalization.

A review of resident #022's health record revealed a physician order for an identified medication, to be administered for three weeks at an identified dosage, then at another identified dosage for six months and reassess. The medication was reordered on three subsequent dates during the six month period, with the stop-date for the medication order five days following the last re-order date.

A review of the progress notes identified that on an identified date approximately one month following the identified medication's stop-date, resident #022 experienced specified symptoms of medical distress, was admitted to hospital and was treated for an identified diagnosis. The hospital's Final Summary Report indicated the resident was not continued on the above mentioned medication after their last discharge from the hospital and this was being investigated by the nursing home physician.

A review of resident #022's Medication Administration Record (MAR) revealed the above mentioned identified medication was stopped five days following the last re-order. On the above mentioned dates the medication was reviewed, the medication was not reassessed to extend or eliminate the six month stop-date entered into the system by pharmacy.

Interviews with the Medical Pharmacist Consultant #178 and ADOC revealed at the time the identified medication was stopped, there were no processes in place, or flags, to reassess the medication stop-date. An interview with the ADOC and DOC confirmed the medication stop date for the identified medication was not reassessed as per the physician's prescription in the written plan of care and therefore in this instance the care was not provided as identified in the written plan of care. [s. 6. (7)]

2. 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.

A CIS was submitted to the MOHLTC on an identified date, which revealed resident #047 had been taken to the hospital and diagnosed with a specified injury.

Review of resident #047's health records revealed they were admitted to the home with identified medical diagnoses and they were at risk for falls. Review of resident #047's current plan of care revealed that they were assisted with transfer by one staff member using an identified assistive device. The plan of care revealed there were identified falls prevention and management interventions to be in place.

Observations by the inspector during the inspection, revealed the above mentioned identified falls prevention and management interventions were not in place at the time of observation.

In an interview, RPN #127 stated that resident #047 was at risk of falls and had a history of an identified behaviour. RPN #127 stated that specified interventions were in place for resident #047 for falls prevention and management. RPN #127 acknowledged that the above mentioned interventions were not in place at the time of observation.

In interviews, RPNs #149 and #150 stated that one of the falls prevention interventions was only used when resident #047 was in bed, RPN #149 additionally stated that the intervention could be a tripping hazard. RPNs #149 and #150 further stated that they

were not aware of the second identified falls prevention intervention being in place for resident #047.

In an interview, ADOC #117 stated that staff on the unit would have access to the resident care plans on the computers and the point of care units. ADOC #117 further stated that it was the expectation of the home for staff on the units to provide care to the residents that is set out in the plan of care. ADOC #117 acknowledged that as the above mentioned falls prevention and management interventions were not in place at the time of inspection, the care set out in the plan of care was not provided for resident #047 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

During stage two of the RQI, resident #012 triggered for personal support services bedfast from the most recent Minimum Data Set (MDS) assessment data.

Observations of resident #012 revealed that the resident was observed to be in bed throughout the time of the inspection.

Review of resident #012's MDS assessment revealed that the resident was bedfast all or most the time. Review of the kardex failed to reveal instructions for staff related to resident #012 being bedfast.

Interview with PSW #116 revealed that the resident #012 had remained in bed recently but was not sure when the plan for the resident to be bedfast began. Interview with PSW #115 revealed that the resident had been bedfast recently to aid in healing an area of impaired skin integrity.

Interviews with PSW #119, RPNs #114 and #157, and the Physiotherapist (PT) revealed that the resident had been on bedrest for an identified time frame related to an area of impaired skin integrity, but were not able to show information about resident #012 being bedfast in the plan of care. RPN #114 further revealed that they had learned that resident #012 was on bedrest after a conversation with ADOC #125.

Interview with ADOC #125 revealed that the resident was put on bedrest on an identified date, when a new area of impaired skin integrity was identified. According to ADOC #125 the interventions in place for healing were not effective and the area of skin integrity was

worsening. Bed rest was initiated for resident #012 on the above mentioned identified date, to improve skin integrity. ADOC #125 further revealed that resident #012's care plan had not been updated after the resident's care needs changed.

Interview with the DOC revealed that it is the home's expectation that residents' care plans are revised when resident's care needs change or care set out in the plan is no longer necessary, and that resident #012's care plan was not revised when the resident's care needs changed. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

During stage two of the RQI Resident #010 triggered for continence care and bowel management from staff interview in stage one.

Review of resident #010's written care plan indicated they were incontinent, and that staff were instructed to use an incontinent product only during a specified time of day. Review of resident #010's Minimum Data Set (MDS) assessment with assessment reference date (ARD) revealed they were incontinent and used pads or briefs.

In an interview, resident #010's substitute decision maker (SDM) stated that resident #010 had been using an identified incontinent product at all times as they could not make the washroom on their own, and needed to call staff when needing to use the washroom.

In an interview, PSW #110 stated that resident #010 was toileted by two staff upon resident request and used an identified incontinent product. PSW #110 additionally stated that resident #010 used an incontinent product throughout the day, and was not sure what the care plan indicated regarding the use of the incontinent product.

In an interview, RN #103 stated that there had been a change in resident #010's continence and recently began using an identified incontinent product on all shifts. RN #103 further stated that the specified incontinent products were used 24 hours a day for resident #010 for a specified time period. RN #103 stated that resident care plans are reviewed and revised quarterly, with change in condition or when an intervention was initiated or discontinued. RN #103 stated the care plan was not revised at the time resident #010's care needs had changed.

In an interview associate director of care (ADOC) #117 stated that the expectation of the

home was for registered staff on the unit to review and revise a resident care plan quarterly, when there is a change in status and when care needs change. ADOC #117 acknowledged that resident #010's plan of care was not reviewed and revised when their continence care needs changed to using briefs 24 hours a day. ADOC #117 acknowledged the licensee had failed to ensure that the resident #010's plan of care was reviewed and revised when the resident's care needs changed [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 the medication management policy required by O. Reg. 79/10, s. 114 (2) was complied with.

As required by the Regulation [O. Reg. 79/10, s. 114 (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.

Review of the home's policy titled Ordering Medications, dated 2017, identified to ensure specific medication, dosage/strength, route, directions, clinical indication, and other pertinent information is identified.

A CIS report was submitted to the MOHLTC on an identified date, for a medication incident which resulted in resident #022 being hospitalized. A complaint was also received by ACTIONline approximately three weeks later, from resident #022's SDM related to the same medication incident resulting in hospitalization.

A review of the progress notes identified that on an identified date resident #022 experienced specified symptoms of medical distress, was admitted to hospital and was treated for an identified diagnosis. The hospital's Final Summary Report indicated the resident was not continued on an identified medication after their last discharge from the hospital and this was being investigated by the nursing home physician.

A review of resident #022's health record revealed a physician order for the above mentioned identified medication, to be administered for three weeks at an identified dosage, then at another identified dosage for six months and reassess. The medication was reordered on three subsequent dates during the six month period, with the stop-date for the medication order five days following the last re-order.

A review of resident #022's MAR for an identified month, revealed the identified was stopped on the identified date five days after the last re-order. The medication was not reassessed to extend or eliminate the stop-date set by pharmacy.

An interview with the Medical Pharmacist Consultant #178, revealed when the physician writes an order, it is transmitted to the pharmacy, will be entered into the electronic medication administration record (EMAR) and the start and stop dates are identified. Similarly, it will be recorded in the pharmacy software. In the three-month medication sheet/review, if the physician sees that medication is about to be stopped, the physician can make a change, including, to change the date, extend and/or discontinue the medication. The identified medication was prescribed by the physician for six months and entered into the EMAR with the identified stop date by the old pharmacy system. In the instructions and three month medication review with the new pharmacy software, it was entered with no indication it would be discontinued. In the EMAR, when the physician re-ordered the medication it was renewed until the stop date identified above, unless the medication was discontinued and reordered with a new stop-date.

An interview with ADOC #117 and DOC revealed the above medication should have been reassessed at the six month time line to extend or eliminate the stop-date set by pharmacy. At the time the medication was stopped, there was no process in place or flag to reassess the medication. No pertinent information related to the stop-date was

identified, therefore the home's policy was not complied with. [s. 8. (1) (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 with ensuring that the medication management policy required by O. Reg. 79/10, s. 114 (2) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy titled Prevention of Abuse and Neglect of a Resident, policy number VII-G-10.00, last revised January 2015, states to "immediately inform the Executive Director (ED) / Administrator and / or Charge nurse in the home any alleged, suspected or witnessed abuse of a resident.

During the resident interview during stage one of the RQI, resident #009 stated they had been handled roughly, had a specified derogatory term used toward them, and informed that the caregiver was the boss and to do what the resident was told.

A review of resident #009's electronic record revealed the resident was cognitively impaired and had memory problems and impaired skills for daily decision making.

During a subsequent interview with the inspector resident #009 identified a staff name, stated the staff member was rude to them saying that they were the boss, the resident had to listen to what the staff said, and did not have time to change incontinent product when asked.

An interview with recreation assistant (RA) #172 revealed that resident #009 had reported that during care a PSW handled them roughly, used a specified derogatory term toward them and what the resident wanted to have happen the PSW did the opposite, for example the resident wants to watch TV and the PSW would draw the curtain and the TV could not be seen. The resident stated they were afraid and did not want this reported. RA #172 reported this situation because it could not be kept a secret and it needed to be reported. RA #172 stated they had reported the incident to RPN #171.

In an interview, RPN #171 denied any knowledge of the incident described above.

An interview with the charge nurse on an identified date, revealed no staff approached them reporting any incident with resident #009.

An interview with ADOC #117, in the presence of the DOC, confirmed the staff did not report the resident #009's allegations of abuse as identified in the home's policy of prevention of abuse, therefore not complying with the policy. [s. 20. (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 with ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD as described in LCTHA 2007, c. 8, s. 33. (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Observation by the inspector during stage one of the RQI resident #002 was observed seated in a position which may have prevented the resident from rising. Minimizing of restraining was triggered in stage two for potential restraints related to this resident observation.

Subsequent observations by the inspector, revealed resident #002 sleeping while seated next to the nursing station on an identified resident home area. Resident #002 was observed seated in an identified mobility device in a position which may have prevented the resident from rising for approximately 45 minutes.

In interviews, RNs #101 and #103 stated that the purpose of a specified function of resident #002's mobility device was for comfort when the resident is asleep while using the mobility device. RN #101 further stated that resident #002 would try to stand up when

the specified function on the mobility device was not engaged. RN #103 further stated that the specified function of the mobility device was considered a personal assistive service device (PASD). RNs #101 and #103 stated that the use of the specified function of resident #002's mobility device should be included in resident's plan of care as the staff were using the function with the resident and an assessment had been initiated for the PASD on the previous day.

Review of resident #002's health records failed to reveal an assessment for the use of the specified function of their mobility device as a PASD. Subsequent review of the resident's health records revealed a PASD assessment had been initiated on the above mentioned identified date by RN #101. Review of resident #002's current care plan failed to reveal the use of the specified function on their mobility device.

In an interview, ADOC #117 stated that it was the expectation of the home that use of the specified function of the mobility device as a PASD was to be included in the resident's care plan. ADOC #117 further stated that when resident #002's mobility device it would limit their freedom of movement. ADOC #117 stated that the use of the PASD was not included in resident #002's care plan at the time of inspection, but was added after the inspector brought this to the attention of the nursing staff. ADOC #117 acknowledged that the PASD was used to assist resident #002 and had not been included in the resident's plan of care. [s. 33. (3)]

WN #5: 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 failed to ensure that resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

A review of the resident #008's paper record revealed dental assessments were offered in two identified previous years. No current dental assessments were identified in the paper record.

A review of the dental assessment form completed by Toronto Public Health (TPH), revealed the resident had a dental assessment on an identified date approximately 20 months prior to the inspection, and was ill when the assessments were completed in the year prior to the inspection.

In an interview the Director of Programs reported that Direct Dentistry was called to confirm if resident #008 was offered a dental assessment in the previous year. No records were located by Direct Dentistry that could confirm resident #008 had been offered a dental assessment in the previous year.

An interview with the ADOC #117 revealed resident #008 was ill when the dental assessments by TPH were held at the home in the previous year, and did not receive a dental assessment. A dental assessment was not offered following the screening period by TPH to the present date.

In an interview, resident #008's SDM stated the resident was not offered a dental assessment in the previous year.

An interview with ADOC #117 confirmed the resident was not offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required. [s. 34. (1) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond to the Family Council in writing within 10 days of receiving advice of concerns or recommendations from the Council about the operation of the home under LTCHA S.O. 2007, c. 8, s. 60. (8).

Record review of Family Council meeting minutes from the meeting which was conducted on October 24, 2017, revealed that council members raised a concern regarding an outside entertainer not appearing at a scheduled October social hour. A Family Council Concern and Recommendation form was initiated dated November 1, 2017, which recommended programs to follow-up on bookings for entertainment to ensure they would be appearing. The concern and recommendation form failed to reveal a response in writing from the Programs department.

In an interview, Family Council representative #202 stated that the concern raised in the October 24, 2017, meeting regarding the entertainment was not responded to in writing.

In an interview, Resident Relations Coordinator (RRC) #121 stated that they were aware of the requirement to respond to concerns or recommendations made by the Family Council in writing in 10 days. RRC #121 stated that the concern was discussed and a process implemented to confirm entertainment bookings which was communicated at the following Family Council meeting. RRC #121 further stated that the Family Council concern and recommendation form was started but had not been responded to in writing. RRC #121 acknowledged that the licensee had failed to respond to the recommendation of Family Council in writing within 10 days of receiving the recommendation. [s. 60. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned: (10) All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

A CIS Report was submitted to the MOHLTC on an identified date, related to an allegation of neglect of resident #032, related to their SDM's concern that the resident was found in bed at an identified time five days prior to the submission of the CIS and the SDM's impression was that they had not been attended to in the preceding hours for personal care at all. The SDM reported the incident to the home through email on the day prior to the submission of the CIS.

Review of the home's Staffing Evaluation Plan, reviewed February 10, 2017, and revised April 18, 2017, revealed that staffing complement for days for all home areas included three PSWs, and one full-time PSW for an identified eight hour period on each home

area for nursing rehab duties.

Review of the Home's staff schedule revealed that on the above mentioned identified date, an identified unit had two PSWs instead of the three as per the staffing plan, and no rehab nursing was assigned on that home area.

Review of the home's investigation revealed that electronic communication was received from the POA of resident #032, alleging that at an identified time on the above mentioned identified date, the POA had found resident #032 in bed without an identified personal care item in place, resident #032 was soiled, and did not appear to have received care prior to the identified time. The POA approached RPN #123 to inquire as to if resident #032 had received care prior to the identified time, and the POA further revealed RPN #123 revealed to the POA that the home was 'short staffed,' and that there was not a PSW assigned to resident #032 for that shift. The RPN then requested another PSW to assist with helping to get resident #032 up for the day.

Resident #032 no longer resided in the home at the time of the inspection.

Review of the home's 'Direct Care Providers – Guideline for reduced resident services during staff shortages' revealed that instructions were provided for when the home area is short of one PSW, two PSWs, or when staffing is at a critical level. Review of the 'Process Map for Replacing Team Members: PSW' revealed that if part-time, casual, and full-time staff were not able to come to replace a staff, PSW staff who are performing other duties were to be reassigned based on operational needs, and the registered staff were to ensure equitable work load and meet residents' needs.

Review of the Home's Job Description for Registered Practical Nurse (RPN), last revised December 2013, revealed that, under the direction of the Nurse Manger and/or Associate Director of Care, the RPN's responsibility included:
- Providing care in accordance with organization policies and procedures, and
- Providing guidance and direction to new team members, students and volunteers.

Interview with the RPN #123 revealed that the incident had occurred when they had recently started working in the home. RPN #123 further revealed that they were not aware of the direct care providers guideline during staff shortages, or the process map for replacing team members, and that these had not been provided to them prior to their beginning work.

Interview with ADOC #117 and the DOC revealed that during orientation, registered staff are provided on-site training with another registered staff on day, evening, and night shift, and during the on-site, the new registered staff would be shown what to do when staff call in sick or were unavailable. However, there was no mandatory checklist item on the orientation to instruct new staff on what to do during staffing shortage, and that the 'Direct Care Providers – Guideline for reduced resident services during staff shortages' and the 'Process Map for Replacing Team Members: PSW' were kept in the staffing binder, but were not part of the orientation for new staff.

ADOC #117 and the DOC further revealed that it is the home's expectation for registered staff, to contact the managers (e.g., ADOC, DOC, ED, manager-on-call), or fellow registered staff for assistance whenever they needed help, and that the manager-on-call was available 24/7.

Interview with RPN #123 could not recall if she had called manager-on-call on the above mentioned identified date when the home was short-staffed. Interview with the manager-on-call revealed that no call was received from RPN #123 on the identified date.

Interviews with the RNs #103 and #112 who worked on the above mentioned identified date, revealed that they had not received any calls or request from RPN #123 for assistance that shift. Interview with PSW #160 revealed that the shift was worked with only two PSW and the RPN, and no rehab staff or other staff had provided assistance on the shift.

Interview with ADOC #117 and the DOC revealed that RPN #123 was not provided with the training on the licensee's 'Direct Care Providers – Guideline for reduced resident services during staff shortages' and the 'Process Map for Replacing Team Members: PSW' prior to beginning work in the home, and that this would be included on future orientation for new registered staff members. [s. 76. (2) 10.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

On an identified date during the RQI, the progress notes for resident #009 for an identified month were reviewed. A notation by physician #168 dated two weeks prior to the progress note review, revealed resident #009 "was on an identified medication last week, mistakenly."

A review of the Physician's Digiorder for resident #009, from an identified date, revealed a telephone verbal order from physician #168 to RPN #170 for a specified medication and instructions for administration. Two diagonal lines were marked through the order with the statement, "error wrong resident." A review of resident #021's Physician's Digiorder from the same date, revealed a telephone verbal order from physician #168 to RPN #170 for the same above mentioned specified medication and administration instructions.

An interview with RPN #114 in the presence of ADOC #117, revealed a phone order was transcribed to resident #009's Physician's Digiorder instead of resident #021's orders. The order was cancelled on the Physician's Digiorder and ordered on resident #021's paper chart. Resident #009 received the aforementioned medication on four consecutive days, with no adverse effect.

The ADOC confirmed resident #009 was not the resident meant to receive the above mentioned specified medication, that it was placed on resident #009's Physician's Digiorder in error and subsequently administered to resident #009. The ADOC confirmed that no drug is to be used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

Issued on this 17th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), IVY LAM (646), JUDITH HART (513), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2018_420643_0002
Log No. / No de registre :	002718-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 11, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Deerwood Creek Care Community 70 Humberline Drive, ETOBICOKE, ON, M9W-7H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Ois

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6. (7).

Specifically, for resident #022 and all other residents develop a process to manage medications to ensure reassessment of the medication:
- when a medication is prescribed (ongoing) with a reassessment date; and
- when a medication is prescribed with a specified stop date and the drug is to be reassessed.

Grounds / Motifs :

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.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, for a recent medication incident which resulted in resident #022 being hospitalized. A complaint was also received by ACTIONline approximately three weeks later, from resident #022's SDM related to the same medication incident resulting in hospitalization.

A review of resident #022's health record revealed a physician order for an identified medication, to be administered for three weeks at an identified dosage, then at another identified dosage for six months and reassess. The medication was reordered on three subsequent dates during the six month period, with the stop-date for the medication order five days following the last re-order date.

A review of the progress notes identified that on an identified date approximately one month following the identified medication's stop-date, resident #022 experienced specified symptoms of medical distress, was admitted to hospital

and was treated for an identified diagnosis. The hospital's Final Summary Report indicated the resident was not continued on the above mentioned medication after their last discharge from the hospital and this was being investigated by the nursing home physician.

A review of resident #022's Medication Administration Record (MAR) revealed the above mentioned identified medication was stopped five days following the last re-order. On the above mentioned dates the medication was reviewed, the medication was not reassessed to extend or eliminate the six month stop-date entered into the system by pharmacy.

Interviews with the Medical Pharmacist Consultant #178 and ADOC revealed at the time the identified medication was stopped, there were no processes in place, or flags, to reassess the medication stop-date. An interview with the ADOC and DOC confirmed the medication stop date for the identified medication was not reassessed as per the physician's prescription in the written plan of care and therefore in this instance the care was not provided as identified in the written plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #022. The scope was determined to be isolated as it related to one of three residents reviewed. The home had a level 4 compliance history as they had ongoing noncompliance with LTCHA 2007, c. 8, s. 6. (7). that included:

- voluntary plan of correction (VPC) issued June 29, 2015 (2015_378116_0007);
- written notification (WN) issued December 2, 2015 (2015_378116_0021);
- WN issued November 14, 2016 (2016_405116_0017);
- WN issued September 12, 2017 (2017_631210_0012);
- VPC issued October 6, 2017 (2017_659189_0016). (513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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Name of Inspector / Nom de l'inspecteur : Adam Dickey

Service Area Office / Bureau régional de services : Toronto Service Area Office