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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2019	2019_759502_0003	004219-18, 007872-18, 009606-18, 021573-18, 024675-18, 028439-18, 002308-19	Critical Incident System

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

JULIENNE NGONLOGA (502), JOANNA WHITE (727)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, February 1, 4, 7 and 8 (off-site), 2019.

The following Critical Incident System (CIS) Report intakes were inspected:
- logs #004219-18 and #024675-18 related to staff to resident abuse,
- logs #009606-18 and #002308-19 related to resident to resident abuse,
- logs #021573-18 and #028439-18 related to injury with unknown cause, and
- log #007872-18 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Environmental Services Manager (ESM), Director of Care (DOC), Assistant Directors of Care (ADOC), Behavioural Support Ontario (BSO), Dietary Aide (DA), Activation Aide (AA), Housekeeping staff (HSK), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Office Manager, Physiotherapist (PT), Director of Dietary Services (DDS), Registered Dietitian (RD), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, residents and family members.

The inspector(s) observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, the home's internal investigation notes, staff schedule and the home's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
4 VPC(s)
0 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. 6. (7)	CO #001	2018_420643_0002	502

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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of a CIS report submitted to the MOHLTC revealed an alleged specified abuse of resident #008 by resident #010. Residents #008 and #010 were observed exhibiting inappropriate behaviours towards each other on an identified date.

Review of resident #010's written plan of care under the focus expression of inappropriate behavior as evidenced by engaging another identified resident in inappropriate behaviour, requires staff to ensure that the yellow wander strip was applied on the resident's door to refrain other residents from wandering into resident #10's room.

On four occasions on identified dates inspector #502 observed that the yellow wander strip was not present on resident #010's door.

An interview with HSK Aide #149 indicated that they were not aware that resident #010's room had needed a yellow wander strip, and they have not seen a yellow wander strip

used on that door.

Separate interviews with PSW #139, RPN #142 and RN #138 indicated that staff should apply the yellow wander strip to deter wandering residents from entering resident #010's room. The above mentioned staff acknowledged that the yellow wander strip was not applied to resident #010's room as it did not stick well onto the door frame. They also confirmed a request was submitted to put stronger velcro on the yellow wander strip.

Review of the maintenance request documentation indicated that on an identified date in January 2019, the above maintenance request for stronger Velcro was received.

Interview with the DOC acknowledged that maintenance staff had not collaborated with nursing staff in the implementation of resident #010's plan of care. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Review of a CIS report submitted to the MOHLTC, indicated that resident #007 exhibited an identified behaviour toward resident #001 resulting in an impaired skin integrity.

Review of resident #007's health records indicated a specified diagnosis, and that the resident was moderately impaired for decision making, with a cognitive performance scale (CPS) score of three out of six. Review of resident #007's care plan indicated the resident was exhibiting specified behaviour towards other residents and staff. The interventions included monitoring resident closely, and redirect other residents.

Progress notes for resident #007 during a twelve month period indicated that resident #007 had exhibited specified behaviours on ten occasions towards other residents and staff.

Interview with BSO #142 acknowledged the above mentioned interventions had reduced the frequency of resident #007's responsive behaviours; however those interventions did not prevent the behaviours from reoccurring.

Interview with ADOC #118 confirmed that the interventions set out in the care plan had not been effective. [s. 6. (11) (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 to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Review of a Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), indicated that resident #007 exhibited inappropriate responsive behaviours toward by resident #001, resulting in impaired skin integrity on an identified date.

Review of resident #001's health records indicated resident #001 had a short and long term memory problem and moderate impairment with a CPS score of three out of six, and specified diagnoses.

Review of resident #007's health records indicated the resident has an identified condition and exhibited an identified responsive behaviour towards other residents and staff. Interventions included monitoring resident closely, and redirect other residents who are wandering in the hallways near resident #007.

Review of progress notes and interview with PSW #116 confirmed the alleged incident mentioned above. PSW #116 further added the incident was witnessed by them, however they couldn't reach the residents in time to prevent the incident.

Separate interviews with PSW #134, RPN #100 and BSO #142 reported the incident between resident #007 and resident #001 on the identified date mentioned above, was considered resident to resident abuse.

Interview with ADOC #118 acknowledged the incident between resident #001 and #007 was considered resident to resident abuse and resident #001 was not protected. [s. 19. (1)]

2. A CIS report was submitted to the MOHLTC on an identified date in January 2019, reporting an alleged incident of abuse of resident #008 by resident #010.

Review of the CIS report indicated that resident #008 and resident #010 were observed exhibiting inappropriate behaviours towards each other..

Review of a MDS assessment indicated resident #010 had modified independence with some difficulty in new situations and a CPS score of two.

Review of a MDS assessment indicated resident #008 was moderately impaired for decision making, with a CPS score of four and specified diagnoses.

Review of resident #008's progress notes indicated the attending physician had assessed this resident after the incident mentioned above, and documented that there was no medication to reduce resident #008's inappropriate behaviour.

Review of resident #008's plan of care indicated that the resident had identified responsive behaviours. They think male residents are their family member. Staff were required to monitor the resident.

Interview with PSW #141 indicated that on the day of the incident, they observed the curtain around resident #010's bed was closed. PSW #141 indicated that they entered resident #010's room and passed the curtain, they observed both resident #008 and resident #010 exhibiting the behaviour identified above. PSW #141 reported they did not know the duration of the incident, before it was witnessed by staff who separated both

residents.

Separate interviews with PSW #139, PSW #141, BSO #142, ADOC #118 and the DOC identified that the above mentioned incident between resident #008 and #010 was considered abuse, as resident #008 did not have capacity to consent to the inappropriate activity. [s. 19. (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 to ensure that residents were protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations.

A CIS report was submitted to the MOHLTC alleging abuse of resident #001 by resident #007on an identified date.

Review of the CIS report confirmed that the home submitted an alleged incident of abuse as mentioned above on an identified date. The CIS report did not report that an investigation had occurred.

Interview with ADOC #118 indicated that the incident of alleged abuse mentioned above was not investigated as the incident was witnessed by staff members. ADOC #118 acknowledged that the incident should have been investigated as per the home's prevention of abuse policy. [s. 23. (1) (a)]

2. A CIS report was submitted to the MOHLTC on an identified date in January 2019, reporting an alleged incident of abuse of resident #008 by resident #010.

Review of the CIS report indicated that resident #008 and resident #010 were observed exhibiting inappropriate behaviours towards each other. The alleged incident was reported to the management team on the same day.

Interviews with ADOC #118 and the DOC indicated that the incident of alleged abuse was not investigated as the incident was witnessed by staff. They acknowledged that the incident should have been investigated as per the home's prevention of abuse policy. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #4: 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 CIS report submitted to the MOHLTC, alleging staff to resident abuse, indicated that resident #002 reported to the charge nurse that at an identified meal PSW #104 used unsafe transfer techniques while assisting them. Then resident also reported that the PSW fed them inappropriately.

During a meeting with the DOC and ADOC, resident #002 stated that on the date identified above, they were leaving the dining room after the meal identified above, PSW #104 used unsafe transfer techniques while assisting them resulting to injury, which was confirmed during a head to toe assessment.

Review of resident #002's health record indicated that the resident has modified independence with a CPS score of two, and requires total assistance from one team member to push the wheelchair due to a specified condition and pain.

An interview with PSW #104 indicated that on an identified date while they were pushing resident #002 out of their room, they did not use safe transfer technique that included to tilt resident #002's wheelchair a little bit due to their specified medical condition. PSW #104 added that they apologized to the resident and reported the incident to the unit nurse.

An interview with PT #147 indicated they assessed resident #002 after the incident mentioned above, and noted a specified injury. PT #147 acknowledged that PSW #104 did not use safe transferring technique when assisting resident #002 as they did not tilt the wheelchair during locomotion through the door. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident:
i. what care was given or action taken as a result of the incident and by whom
ii. whether a physician or Registered Nurse in the Extended Class was contacted
iii. what other authorities were contacted about the incident, if any
iv. whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was submitted to the MOHLTC related to injury with unknown cause.

Review of the CIS related to injury with unknown cause indicated that on an identified date, the PT assessed resident #001's transfer and ambulation status and noted altered skin integrity on a specified body part.

Review of resident #001's health records indicated that on the same day, the attending physician assessed resident #001 and noted specified altered skin integrity on a specified body part and ordered an X-ray. On the next day, the X-Ray result indicated a specified injury.

Three days after the physiotherapist assessment, the home submitted a CIS report which indicated that the above mentioned CIS report will be amended upon completion of the investigation.

Review of the home's investigation records indicated that the investigation was completed, however the home was unable to identify the specific incident which resulted in resident #001's injury mentioned above.

Interview with ADOC #118 acknowledged that the above mentioned CIS report was not amended after the home's investigation was completed. [s. 104. (1) 3.]

Issued on this 15th day of March, 2019

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

Original report signed by the inspector.