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_0004	005942-18, 011770-18	Complaint

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)

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): January 22, 23 and 30, 2019.

Two complaints (#005942-18 and #011770-18,) related to multiple care concerns were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Supervisor (HS), Housekeeping staff (HSK), a resident and a family member of the resident.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 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	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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (3) The licensee shall ensure that a sufficient supply of housekeeping equipment and cleaning supplies is readily available to all staff at the home. O. Reg. 79/10, s. 87 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was sufficient supply of housekeeping equipment and cleaning supplies readily available to all staff at the home.

Various complaints were submitted to the MOHLTC related to multiple care areas. The complainant reported that they did not permit the staff to enter resident #003's room for the purposes of cleaning and sanitation. Instead the complainant attempted to clean and sanitize the room independently. The complainant indicated that on an identified date in January 2019, they were not able to clean the resident's room, because the cleaning supplies were not available in an identified resident care area.

On two occasions in an identified period, the inspector observed resident #003 sleeping in their bed, and there was an identified offensive odour present in the room.

On an identified date, the inspector observed that the cleaning supplies were not available on an identified resident care area.

In an interview, PSW #146 indicated that resident #003's room always had the offensive odour identified above, as housekeeping staff were not allowed to enter the resident's room to clean it. PSW #146 further indicated that the substitute decision maker (SDM) always attempted to clean the resident's room when they visited.

In an interview, Housekeeping staff (HSK) #121 stated that at the beginning of their shift the container of cleaning supply used to clean the floor was empty. HSK #121 acknowledged that there was no cleaning supply available, and as a result water was added to the empty container. HSK #121 informed the Housekeeping Supervisor (HS) #124 that there was no cleaning supply available on the unit during their shift.

An interview with HS #124, indicated that the resident's SDM attempted to clean the resident's room independently, as they refuse access to housekeeping staff. HS #124 acknowledged they were informed by HSK #121, that there was no cleaning supply available on the resident care area identified above, and it should have been replenished. HSK #124 had not provided the cleaning supply on the identified resident care area at the time of the interview. [s. 87. (3)]

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 there was sufficient supply of housekeeping equipment and cleaning supplies readily available to all staff at the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference was fully respected and promoted.

Various complaints were submitted to the MOHLTC related to multiple care areas.

Review of the complaints indicated that the complainant stated that they were not allowed to visit resident #003 at the home after 2100 hrs. The complainant alleged that resident #003's health status had changed to specified care following their discharge from a specialized care centre, and they wanted to have 24 hour access for visiting.

The complainant alleged that the home did not allow them 24 hour access, as they were retaliating due to previous multiple complaints that were submitted to MOHLTC.

The complainant reported that on an identified date in 2018, they were informed by the unit staff to leave the home at 2100 hrs when the home's visiting hours end.

Review of resident #003’s health record indicated that the resident was bedridden with identified diagnoses.

Review of resident #003’s progress notes indicated that on an identified date, the resident’s SDM was unhappy with the care provided to the resident. The progress notes further indicated that the SDM had inappropriate behaviours towards the staff.

Further review of the progress notes indicated that two days later, the Executive Director (ED) documented that they met with the SDM, who exhibited inappropriate behaviour toward them.

The ED advised the SDM that if they continued misconduct it may result in limitations to visiting hours, and supervision would be provided by the management team.

Review of Visitor Sign in sheet indicated that the resident's SDM visited six days in an identified period of time.

In an interview, RN #126 indicated that resident #003’s SDM exhibited inappropriate behaviour toward staff and other residents, therefore they were only allowed to stay up until 2100 hrs when they visit. RN #126 further added that they used their discretion to permit the SDM to stay on the unit pending completion of resident #003’s evening care.

In an interview, RN #127 indicated that in the previous shift they had worked, and had reminded resident #003’s SDM not to extend their visit with resident #003 past 2100 hrs.

In an interview, the ED indicated that after the incident mentioned above, the home informed the SDM on an identified date in 2018 that the restriction needed to be imposed to minimize any encounter with the team member involved. As result of the restriction, the SDM was to leave the building by 1900 hrs when they visited, then it was extended to 2100 hrs when no further incident was noted.On an identified date, the employment status of the team member mentioned above changed to casual and the restriction was lifted. The ED was not aware that staff were interfering with visit. They acknowledged that resident #003's visit with their SDM was being interfered with by evening registered nursing staffs. [s. 3. (1) 14.]

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.