Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Aug 8, 2019	2019_810654_0001	010681-19	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

SIMAR KAUR (654)

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): July 18, 19, 23, 24, 25, and 26, 2019.

Intake log #010681-19 was inspected during the inspection related to resident's right to provide consent and continence care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physician, Resident Assessment Instrument-Minimum Data Set-Coordinator (RAI-MDS-C), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents, and Resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services

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. 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A complaint #010681-19 was submitted to the Ministry of Long- Term Care (MOLTC) related to resident #001's incontinence care not being provided. The complainant indicated that they visited resident #001 every day for an identified time period. They indicated that the staff does not check and change the resident's continence care product during the time of their visit.

Review of resident #001's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) indicated that the resident was totally incontinent of bowel and bladder. The resident had severe cognitive impairment which indicated never/rarely made decisions.

Review of resident #001's progress note indicated a history of Infections. Review of the resident's plan of care did not identify individualized interventions for bowel and bladder continence care, specifically when the resident is with a family member for prolonged hours.

Interview with PSW #105 indicated that resident #001's family member visited them every day for an identified time period. The family member takes the resident off the unit. The PSW stated that they don't check and change the resident's continence product if the resident is with a family member from the start of the shift until the family member leaves. The PSW further stated that they do not provide the resident with assistance with continence care between the time period, when they were with the family member.

Interview with RPN #107 indicated that evening PSWs were responsible to provide continence care to the resident before an identified meal service. The RPN indicated that they did not know that the resident was not being provided with continence care during daily family visits. They further indicated that registered staff did not include resident #001's continence care needs on the plan of care, according to their family visits as they were not notified by the PSWs. Interview with another RPN #104 indicated that resident #001's plan of care did not include specific information to direct PSW staff on how often to check and change their continence product when they were with a family member.

Interview with RAI-MDS-C #102 indicated that according to the home's practice incontinent residents are provided continence care before, after each meal, and as needed during each shift. PSWs were responsible to check and change the resident's

continence product during family visits. RAI-MDS-C #102 further indicated that resident #001's plan of care had not been individualized to promote and manage bowel and bladder continence.

Interview with the DOC indicated that the staff are responsible to ensure that continence care is provided to the residents when they are with their family members. Resident #001's plan of care should have been individualized based on an assessment of their family's visiting hours to promote and manage bowel and bladder continence. [s. 51. (2) (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 the residents who are incontinent have an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and the plan, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001's SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint #010681-19 was submitted to the Ministry of Long- Term Care (MOLTC) related to resident #001's SDM not being notified about new physician orders.

Review of resident #001's RAI-MDS assessment indicated that the resident had severe cognitive impairment and never/rarely made decisions. Further review indicated the complainant was SDM for their care.

Review of the resident #001's health record indicated three new identified physician orders on three identified dates.

Further review of the above-mentioned physician order sheets indicated no registered staff signature under the SDM consent section. Review of resident #001's progress notes did not indicate that the resident's SDM was notified about the above-mentioned orders.

Interview with RPN #107 indicated that registered staff are required to inform resident/SDM of any change with the physician orders and sign on the physician order sheet. After the review of resident #001's physician order sheets and progress notes, RPN #107 indicated that the resident's SDM was not notified of the two above-mentioned orders on the identified dates. The RPN further indicated that the attending physician spoke with the SDM after they prescribed the third order. Interview with attending Physician #110 acknowledged that the SDM did not consent to the third order as mentioned above.

Interview with the DOC indicated that registered staff are responsible to obtain the consent from residents/SDMs for any new physician order and document on the order sheet. DOC acknowledged that resident #001's SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

Issued on this 20th day of August, 2019

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

Original report signed by the inspector.