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
Sep 12, 2017	2017_631210_0012	032413-16, 007527-17, 010973-17, 011588-17, 015628-17, 016114-17	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Deerwood Creek Care Community
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

SLAVICA VUCKO (210)

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 24, 25, 26, 27, 28, 31, August 1, 2, 3, 4, 8, 9, 10, 14, 15, 16, 17, 18, 21, 22, 23, and 24, 2017

The following complaints were concurrently inspected: #032413-16 related to maintenance services, 007527-17 related to responsive behaviour, care plan, medical services, cooling requirements, 010973-17 related to plan of care, pain management, continence care and bowel management, prevention of abuse and neglect, 011588-17 related to transferring and plan of care, 015628-17 related to pest control, pain management, infection prevention and control program, plan of care, residents' drug regimes, duty to protect, personal care, nursing and personal support services, 016114-17 related to plan of care, residents' bill of rights, residents' drug regimes.

During the course of the inspection, the inspector(s) spoke with family members, the resident, Executive Director, Acting Director of Care, Assistant Director of Care, Social Worker, Registered Dietitian, Nutrition Services Manager, Programs Manager, Director of Environmental Services, recreation staff, registered nursing staff, personal support workers. The inspector observed the provisions of care, medication administration, snack delivery and reviewed the resident's clinical record.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Critical Incident Response
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Skin and Wound Care
Snack Observation

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	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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
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).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another

person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license failed to ensure that the resident right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

A written complaint was submitted from resident #027's family member to the home in regards to how the resident was treated by staff. The home forwarded the complaint to MOHLTC.

According to the complaint, on an identified date during day shift, PSW #114 entered the room of resident #027 to answer the call bell. A review of the video footage of the camera in the room revealed the staff covered his/her mouth with the top while talking to the resident. The resident asked the staff if it really smelled. Staff answered that was the reason why he/she wanted to provide care before having the meal.

Interview with PSW #114 revealed resident #027 was known to demonstrate a specific responsive behaviour. The resident could refuse care for periods as long as an entire shift. The registered staff RN #115 told PSW #114 that in the morning probably the resident was not changed for longer period of time and that the room smelled. PSW #114 revealed staff could use masks that are available on the unit, in situations with strong odors. He/she did not use a mask on the identified date, because he/she thought it would be a quick interaction with the resident and if the resident agreed to the care the staff would have applied the mask when providing care. During an interview with resident #027 he/she was not able to recall the incident.

A review of the home investigation file, the video footage and interview with interim DOC confirmed resident #027 was not treated with respect and dignity on an identified date. [s. 3. (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 the resident right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.

A review of resident #027's written plan of care revealed PSW to serve 125 ml of an identified beverage at evening snack from the snack cart. Dietary staff are to serve 250 ml of an identified fluid at supper as per family member's request.

A review of the snack delivery report that was attached to the snack cart on an identified date, at afternoon time, revealed resident #027 to receive 125 ml of a beverage different from what the written plan of care indicated before going to bed (HS).

Interview with DSS staff #126 indicated that the resident #027 receives the identified beverage for lunch but not for evening snack, and confirmed that the snack delivery report was not reflecting the written care plan. [s. 6. (1) (c)]

2. An interview with resident #027's family member revealed an identified type of personal care of the resident was not provided during identified time period by the home staff and that he/she has performed this specific personal care several times using a specific aid that is located in the resident room. He/she was not able to visit the resident for a specified time period and he/she was not sure if the home was able to perform the specific type of personal care using the specific aid. He/she has never been asked by the home staff for help with resident #027's specific type of personal care.

A review of resident #027's written plan of care revealed the family to be involved in the specific type of personal care because the resident does not like this type of care to be provided to him/her.

Observation on an identified date and time revealed a specific aid for personal care located in resident #027's room.

Interview with staff #114 revealed he/she did not ask the resident for a specific type of personal care on an identified bath day, because the resident was known to refuse this type of care. Staff #114 revealed he/she did not have any knowledge that resident #027's should be provided personal care with the specific aid that was located in the resident's room. Interview with registered nurse staff #115 revealed that he/she has noticed on several occasions that resident #027's family member seemed as performing a specific personal care to the resident but he/she was not sure if this type of care was actually completed. Further staff #115 revealed the home staff is not involved in the specific personal care of resident #027 using the specific aid located in resident #027's room. Interview with resident #027 revealed he/she would like the specific personal care to be performed by staff if they know how to use the specific aid and his/her family member was present.

Interview with staff #115 confirmed the written plan of care did not give clear direction to staff in regards to the use of the specific aid when performing the specific personal care to resident #027. [s. 6. (1) (c)]

3. 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.

An interview with resident #027's family member revealed a specific personal care of the resident was not performed for an identified time period by the home staff and that he/she has performed the specific personal care several times using a specific aid that is located in the resident's room. He/she revealed he/she had not been asked by the home staff for help with resident #027's specific personal care for an identified time period.

A review of resident #027's written plan of care revealed the family to be involved in the specific type of personal care because the resident does not like this type of care to be provided to him/her.

Interview with staff #114 revealed he/she did not ask the resident for the specific personal care on an identified bath date, because the resident was known to refuse this type of care. Interview with staff #115 revealed the home staff is not involved in resident #027's specific personal care and they have not requested help from the resident's family member on an identified bath day.

Interview with staff #115 confirmed that on an identified date, the home did not request help from resident #027's family member to perform a specific type of personal care as per the written plan of care. [s. 6. (7)]

Issued on this 25th day of September, 2017

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

Original report signed by the inspector.