Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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, 2020	2020_770178_0003	001436-20	Complaint

Licensee/Titulaire de permis

Deep River and District Hospital
117 Banting Drive DEEP RIVER ON K0J 1P0

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

The Four Seasons Lodge
117 Banting Drive DEEP RIVER ON K0J 1P0

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

SUSAN LUI (178)

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): February 18, 19, 20, 21, 2020 onsite; February 24, 26, 27, 2020 offsite.

Complaint Log #001436-20 regarding resident care, was inspected.

During the course of the inspection, the inspector(s) spoke with residents, family of a resident, a mobility aid technician, Personal Support Workers (PSWs), the Physiotherapy Assistant, the Physiotherapist, Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Occupational Health/Infection Prevention and Control RN, the Director of Care (DOC), the Administrator.

During the course of the inspection, the inspector also observed the provision of care and services to residents, observed residents' environment, reviewed residents' health records, reviewed licensee records and policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Minimizing of Restraining
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan, with regards to the care of the

resident's personal aids.

a) Resident #001 had cognitive impairment and required assistance with activities of daily living, including care of the resident's specified personal aids. Resident #001's substitute decision maker (SDM) indicated that after a number of resident #001's specified personal aids were lost, a procedure was initiated in which staff would check the resident every hour to see if the resident's specified personal aid was in place.

Resident #001's plan of care indicated that the resident's specified personal aid was to be checked every hour. Progress notes indicated that on an identified date at bedtime, it was discovered that resident #001's specified personal aid was missing.

RPN #103 indicated that staff was supposed to check every hour to ensure that resident #001's specified personal aid was present. This measure had been introduced because the resident had a tendency to remove their specified personal aids and had lost them in the past. RPN #103 indicated that on an identified date, the resident had been out of the home on an outing with recreation staff. When the resident returned to the home it was not noticed until later in the evening that the specified personal aid was missing, and it was not clear whether the resident had returned to the home from the outing with the personal aid. The long-term care unit and the outing location were thoroughly searched but the specified personal aid was not found.

The DOC provided a copy of an email between RPN #103 and RPN #112 from the an identified date. The email indicated that at bedtime the staff was unable to locate resident #001's specified personal aid and that staff on evenings had not noticed if the resident had the specified personal aid during the shift. The email indicated that the resident had been on an outing that day and staff did not know whether the resident had the specified personal aid when they returned from the outing. In the email, RPN #103 indicated that they had not checked the specified personal aid.

PSW #111 worked as a Behavioural Supports Ontario (BSO) worker and as a PSW on resident #001's unit around the time the resident lost their specified personal aid. PSW #111 indicated that on the day the resident's specified personal aid went missing, the resident had been on an outing, which PSW #111 had attended as BSO staff. PSW #111 was not aware of whether the resident had the specified personal aid during the outing, did not check for the specified personal aid every hour, and was not aware that this was part of the resident's plan of care.

b) Resident #001's plan of care indicated that registered staff was to ensure that resident #001's specified personal aid was removed by staff and given to the RPN to store in the medication room when the resident napped.

On an identified date, Inspector #178 observed resident #001's specified personal aid on the shelf in the resident's room while the resident napped in bed.

PSW #106 worked full time on resident #001's unit and indicated that resident #001's specified personal aid was stored on the shelf in the resident's room when the resident napped. PSW #109 worked part time on resident #001's unit and indicated that some staff brought resident #001's specified personal aid to the medication room when the resident napped, but some staff left it in the resident's room during naps. RPN #103 worked full time on resident #001's unit and indicated that some PSWs did not bring the resident's specified personal aid to them when the resident napped, and in those cases RPN #103 would retrieve it from the resident's room themselves.

As such, the licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 has been prescribed for the resident.

Progress notes for resident #001 indicated that on an identified date, the resident was administered a specified vaccine in error. The resident's substitute decision maker (SDM) had refused consent for the resident to receive the specified vaccine for specified medical reasons. Resident #001's plan of care indicated that the resident could not take the specified vaccine, and the resident's medical record contained no physician's order for the specified vaccine.

RPN #104 indicated that they administered the specified vaccine to resident #001 in error because they were administering the vaccine to a number of residents at the time, and did not realize that resident #001's consent form indicated that the SDM declined for the resident to receive the specified vaccine. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 28th day of February, 2020

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

Original report signed by the inspector.