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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Aug 24, 2017	2017_547591_0013	017264-17	Resident Quality Inspection

Licensee/Titulaire de permis

PEEL HOUSING CORPORATION
10 Peel Centre Drive, Suite A BRAMPTON ON L6T 4B9

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

VERA M. DAVIS NURSING HOME
80 Allan Drive Bolton ON L7E 1P7

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

NATASHA JONES (591), SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 31, August 1, 2, 3, 8, 9, and 10, 2017.

The following Critical Incident inspections were completed concurrently with this RQI:
032040-15 related to abuse
007441-16 related to abuse
009202-16 related to abuse
020510-16 related to abuse
025070-16 related to abuse
029962-16 related to abuse
030227-16 related to abuse
032895-16 related to abuse
003989-17 related to abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisor of Care (SOC), Activations Supervisor, Dietary Services Supervisor, registered staff, personal support workers (PSWs), house keeping staff, Resident's and Resident's family members.

During the course of the inspection, Inspectors reviewed resident health records, investigative notes, complaint logs and files, infection control surveillance documentation, staff files, program evaluations, policies and procedures, toured the home, conducted interviews of staff, family and residents, and observed residents and care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **4 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. 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Observations in 2017, revealed the resident used device "A" and device "B". The resident could not be interviewed due to their medical condition. A review of the resident's current written plan of care, identified both device "A" and "B" as restraints, used for the resident to promote comfort, prevent injury, and as a result of their medical condition. A review of the most recent assessment titled "PASD/Restraint", identified device "A" as a restraint, and device "B" as a personal safety assistance device (PASD). A review of the most current resident assessment instrument (RAI), minimum data set (MDS), indicated devices and restraints were not used for the resident. A review of the resident's most recent physician's order identified device "B" as a restraint and another order identified device "A" as a PASD. In interviews, registered staff, and personal support workers (PSW)s stated device "A" was used as a restraint for the resident and device "B" was used as a PASD. In an interview, the RAI coordinator confirmed that the assessments related to restraints and PASDs for the resident were not integrated or consistent and did not complement each other. They further confirmed the device "A" was a restraint and

device "B" was a PASD. [s. 6. (4) (a)]

2. The licensee 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 resident's care needs changed or care set out in the plan was no longer necessary.

A) A resident required two staff for lifts and transfers, and one staff for assistance with their personal care, as per the last Minimum Data Set (MDS) assessment. In an interview, the resident stated that they sometimes refused the care at a certain time of the day related to their condition, further stating that they preferred to have the personal care at a specified time. A review of the personal care schedule indicated that the resident's specified care was scheduled on specified dates and times. A review of the resident's personal care records indicated that three out of four most recent attempts to provide the resident with the personal care were refused and alternative care was given instead. In an interview, a PSW stated that the resident often refused the personal care, which they had not informed the registered staff of. In an interview, the registered staff indicated that PSW staff had not informed them of the resident's refusals of the personal care therefore no reassessment or revisions to the resident's plan of care were completed. In an interview, the Director of Care (DOC) confirmed that the resident was not reassessed and the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

3. B) A review of the resident's MDS assessment, indicated that the resident had a specified medical condition which affected their ability to request assistance with an activity of daily living (ADL). A review of the progress notes indicated that the resident was on a specified program related to the ADL. A review of the resident's written plan of care, indicated that the resident was on a specified schedule and program related to the ADL. In an interview, a PSW confirmed the resident's medical condition, and indicated that the staff provided care for the resident at regular intervals. In an interview, a registered staff indicated that registered staff were responsible for updating resident written plans of care as necessary, and confirmed that the resident's schedule related to the ADL was no longer in effect but remained on their plan of care.
In an interview, the DOC confirmed that the resident's written plan of care was not revised when their care needs changed. [s. 6. (10) (b)]

4. C) A resident had a history of specified behaviours. The resident was involved in three incidents in 2016, in which the resident entered another resident's room and an incident

occurred. In an interview, a registered staff indicated that as a result of the resident, specified interventions were implemented to prevent a reoccurrence of the incidences between the residents. A review of the resident who had the behaviour's health record and written plan of care, did not include the specified implemented interventions as a result of the incident. In an interview, a registered staff indicated that the interventions were included in one resident's written plan of care but not in the other resident's written plan of care. In an interview, the DOC confirmed that the registered staff failed to revise the resident's written plan of care when their care needs changed.

D) A resident had a history of specified behaviours. In an interview, a PSW indicated that the resident displayed behaviours during a specified time of the day. They further indicated that this behaviour had increased in frequency. The PSW indicated that the staff, with the consent of the resident's substitute decision maker (SDM), would employ the use of a device to manage the behaviour. A review of the resident's written plan of care did not include the resident's specified behaviour, and did not include the use of the device as an intervention to manage the behaviour. In an interview, the DOC confirmed that the registered staff failed to revise the resident's written plan of care when the resident's care needs changed.

E) A review of a resident's written plan of care did not include any interventions to protect them from ongoing incidences involving another resident. In an interview, a PSW indicated that PSW staff were directed to implement a specified intervention to ensure the safety of one of the residents from the other. In an interview, a registered staff indicated that interventions were implemented to ensure the safety of the resident. A review of one of the resident's written plan of care did not include interventions to prevent further incidence between the two residents. In an interview, a registered staff indicated the intervention was not updated in the written plan of care. In an interview, the DOC confirmed that the registered staff failed to revise the resident's written plan of care when the resident's care needs changed. [s. 6. (10) (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 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, to be implemented voluntarily.

WN #2: 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 of a long-term care home failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee was immediately investigated; abuse of a resident by anyone.

A review of the progress notes for a resident indicated that in 2017, a staff member witnessed an incident between two residents. The progress note, entered by a registered staff indicated that they were informed of the incident by another registered staff who initially received the report of the incident. In an interview, the registered staff indicated that they did not report the incident because they were under the impression that the other registered staff would report the incident to whom it was initially reported. A review of the home's policy titled, "Prevention, Reporting and Elimination of Abuse/Neglect", policy # LTC1-05.01 stated, "Any person who has witnessed or has reasonable grounds to suspect abuse or neglect of a resident must immediately make a report to the centre's Administrator/designate and the Director of MOHLTC". A review of the current outstanding Critical Incident reports filed by the home did not indicate that there was a report made to the Director of this incident. An interview with the DOC confirmed that the incident was not reported to the home's leadership, no internal investigation was initiated, and no report to the Director was made. [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 of the following that the licensee knows of, or that is reported to the licensee is immediately investigated; abuse of a resident by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A) A resident had a history of a specified medical condition with related treatment. In 2016 a visitor of the resident noted altered skin integrity of the resident. A review of the resident's health record and written plan of care, indicated that the resident had history of a condition related to the altered skin integrity. A review of the resident's health record did not indicate that any assessment related to the altered skin integrity were completed for the resident. In an interview, a registered staff indicated that during that time period, staff did not conduct assessments using a clinically appropriate tool for the type of altered skin integrity the resident had, as their policy did not direct them to; however, they documented a summary of their assessments in the progress notes. In an interview, the DOC confirmed that the home's policy had since been changed to accurately reflect the legislative requirements pertaining to skin and wound assessments. The DOC confirmed that the registered staff did not complete skin and wound assessments using a clinically appropriate assessment tool for the resident's altered skin integrity. [s. 50. (2) (b) (i)]

2. B) Observations of a resident in 2017, revealed they had altered skin integrity. A review of the home's policy #LTC9-05.09.02, titled "Skin and Wound care program", included the altered skin integrity and further indicated a weekly skin and wound assessment should be completed on point click care (PCC) for all altered skin integrity and documented in the progress notes. A review of the skin and wound assessments in PCC for the resident revealed no skin assessments were completed. A review of point of care (POC) documentation indicated the resident did not have altered skin integrity. A review of the resident's current written plan of care did not include interventions related to the altered skin integrity. Interviews with a registered staff and two PSWs confirmed the altered skin integrity was present on the resident, was not reported to registered staff and no skin assessment was completed. In an interview, the Supervisor of Care (SOC) confirmed a skin assessment for altered skin integrity should have been completed for the resident. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A resident had a specified medical history and specified behaviours. In 2016, an incident was witnessed whereby the resident exhibited behaviours, and exhibited similar behaviours in another resident's room on two separate occasions. A further review of a report indicated that a registered staff had witnessed an incident whereby the resident displayed the behaviours and noted that this behaviour was increasing in frequency. The Long-Term Care Home (LTCH) Inspector was unable to locate documentation of this in the resident's health record. In an interview, a PSW indicated that PSW staff were aware of the resident's specified behaviours and would implement interventions to manage the behaviours as needed. A review of the resident's written plan of care, indicated that the resident exhibited some of the specified behaviours due to their medical condition but did not include all of their specified behaviours. A review of the resident's health records did not indicate that any referrals or behavioural assessments had been completed. In an interview, a registered staff indicated that when the resident displayed new behaviours, no referral to the Behavioural Supports Ontario (BSO) staff was made. A review of the progress notes indicated that the BSO staff was referred to, related to a newly prescribed treatment for their medical condition. In an interview, the DOC confirmed that the resident did not receive an assessment by the BSO nurse when they exhibited new specified behaviours. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 26th day of August, 2017

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

Original report signed by the inspector.