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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 19, 2022	2022_890758_0005	003233-22, 006725-22	Complaint

Licensee/Titulaire de permis

Peel Housing Corporation
10 Peel Centre Drive Suite B, 4th Floor Brampton ON L6T 4B9

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

Vera M. Davis Community Care Centre
80 Allan Drive Bolton ON L7E 1P7

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

DANIELA LUPU (758)

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): March 24-25, March 28-31, and April 1, 2022.

The following intakes were completed during this complaint inspection:

Log #003233-22, related to resident care and falls prevention and management program;

and

Log #006725-22, related to resident care and operations of the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (A-DOC), Infection Prevention and Control (IPAC) Lead, Registered Nurses (RNs), Personal Support Workers (PSWs), a housekeeping staff, an activation staff and residents.

The inspector(s) observed staff to resident interactions, meals and snack services and infection prevention and control practices. They also reviewed clinical records, the home's policies and procedures, and documents pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Pain
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Pain Management Program was complied with for three residents.

According to O. Reg. s.48 (1)(4), and in reference to O. Reg. s.52 (1)(4), the licensee is required to develop and implement an organized program for pain management that includes the monitoring of resident's responsiveness to, and effectiveness of, pain management strategies.

The home's Pain Management Program directed Personal Support Workers (PSWs) to recognize, screen and report resident signs indicative of discomfort/pain to the registered staff. The registered staff were to complete a pain assessment utilizing the home's pain assessment tool when positive signs of pain were identified, re-assess the effectiveness of pain interventions within a specified time interval and complete a pain reassessment.

A. A resident had pain due to their medical diagnosis and needed help from staff members for mobility and care.

The resident was noted with new pain to a specific area when staff touched the area to provide them with care. The resident continued to show non-verbal signs of pain when the affected area was touched, as they were repositioned or provided with care during the shift. A PSW said they did not report the pain to the registered staff or document the pain in Point of Care (POC) when it was first noticed.

The next day, the resident was noted with an injury and pain to the specific body area and they received as needed (PRN) pain medication. The effectiveness of this intervention was not evaluated within the required time frame.

The A-DOC said the staff should have reported pain as soon as possible to the registered staff and documented as needed in POC. They also said the effectiveness of the pain interventions should have been evaluated as indicated in the home's pain policy.

By not reporting the pain when it was first noted, it resulted in a delay in identifying the resident's injury, and implementation of assessments and appropriate interventions. Additionally, not assessing the effectiveness of pain management interventions within the recommended time frame, increased the risk that appropriate measures were not implemented in a timely manner.

Sources: a resident's clinical records, the home’s pain policy, the home's investigative notes and interviews with the A-DOC, PSWs, and other staff.

B. On three consecutive days, a resident had pain and received PRN pain medication on each occasion, in addition to their scheduled pain medications. The effectiveness of these interventions were not evaluated within the specified time frame after administration.

On a different occasion, the resident had responsive behaviours towards staff and stated they had pain. They received their scheduled pain medication, but their pain was not assessed nor the effectiveness of the intervention evaluated within the needed time interval after administration.

Additionally, there were no pain assessments completed in the above indicated time period, when the resident had pain.

C. A resident had pain and was noted restless despite non-pharmacological interventions being provided. The resident received PRN pain medication, but the effectiveness of this intervention was not evaluated as needed and there was no pain assessment completed.

The A-DOC said that a Complete Pain Assessment should have been completed when the resident was identified with pain. They also said the effectiveness of the pain interventions should be evaluated, as indicated in the home's pain policy.

By not completing a pain assessment and assessing the effectiveness of interventions

after pain medication administration within the recommended time frame, increased the risk that appropriate measures were not implemented in a timely manner if the pain interventions needed adjustments.

Sources: the clinical records for two residents, the home's pain policy, and an interview with the A-DOC. [s. 8. (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 staff comply with the home's pain management program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program in relation to resident hand hygiene practices.

A. The home's hand hygiene policy directed staff to help residents to wash their hands before and after meals. The policy also documented that hand hygiene was to be provided according to the "Just Clean Your Hands" program.

The "Just Clean Your Hands" Implementation Guide, Ontario's Step-by-Step Guide, indicated that residents' hands were to be cleaned before and after meals and snacks.

During a lunch meal service, seven residents were not provided or encouraged with hand hygiene before eating and three residents after eating their meals. Additionally, during a

breakfast meal service, nine residents were not provided or encouraged with hand hygiene after eating.

During a snack service, five residents were not provided or encouraged with hand hygiene before they received their snacks. On a second occasion, during a snack service in a different home area, two staff did not provide or encourage four residents with hand hygiene before they received their snacks.

The home's IPAC Lead said residents should be encouraged or provided with hand hygiene before and after meals and snacks. They also said the home was following hand hygiene practices according to the "Just Clean Your Hands" Program.

Sources: observations of the meals and snack service, the home's hand hygiene policy, Just Clean Your Hands Implementation Guide Ontario's Step-by-Step Guide, September 2020, and interviews with the home's IPAC Lead, PSWs and other staff.

B. The home's hand hygiene policy documented that the home will follow hand hygiene practices as per the Best Practices for Hand Hygiene in All Health Care Settings.

Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Hand Hygiene in All Health Care Settings, documented the preferred method for hand hygiene when hands were not visibly soiled was using an alcohol-based hand rub (ABHR) containing 70 to 90 per cent alcohol.

During the lunch meal service on two different occasions, 18 residents were assisted with hand hygiene after they finished eating, using wet warm towels which contained plain water. Additionally, during a breakfast meal service, five residents were assisted with hand hygiene using wet warm towels.

The home's IPAC Lead said that wet towels did not sanitize the residents' hands. The wet towels should be used to clean residents' hands if soiled, followed by the use of ABHR.

Gaps in the implementation of the home's infection prevention and control program related to resident hand hygiene practices increased the risk of possible exposure and transmission of viruses and bacteria to residents, staff and visitors.

Sources: observations of the meal service, the home's hand hygiene policy, PHO-

PIDAC- Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, April 2014, and interviews with the home's IPAC Lead, RNs, and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the home's IPAC program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written incident report related to a resident's injury of unknown cause and a change in their condition included the long-term actions to correct the situation and prevent recurrence.

A resident was noted with an injury for which they were transferred to the hospital and resulted in a change in their condition. The incident report was not amended to include long-term actions to prevent recurrence.

The home's A-DOC stated that the incident report should have been updated to include the long-term interventions.

Sources: critical incident report and an interview with the A-DOC. [s. 107. (4) 4.]

Issued on this 21st day of April, 2022

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

Original report signed by the inspector.