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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 23, Aug 12, 2014	2014_278539_0011	H-000469-14	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

VALERIE GOLDRUP (539), DARIA TRZOS (561), DIANNE BARSEVICH (581), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 29, 30, May 1, 2, 5, 6, and 7, 2014.

The following two inspections, H-000370-14 and H-000761-13 were completed simultaneously with this inspection. No findings of non-compliance were found.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nursing staff including the Director of Care (DOC),the Resident Assessment Instrument (RAI) Coordinator, the Supervisor of Care, Program Support Nurses, Registered Nurses(RN), Personal Support Workers (PSW), the Supervisor of Activation, the Supervisor of the Adult Day Program, the Registered Dietician,the Food Service Manager, the Cook, Food Service staff, Activation staff, residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 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 did not ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

On April 4, 2014, the clinical record indicated that Resident #11 sustained an unwitnessed fall in their room. Upon further review of the documentation, the date of the fall was not updated in their care plan as per the home's policy. The care plan indicated that their last fall was January 16, 2014.

The home's Fall Management Program stated that Registered Staff were to update the resident's care plan to reflect the changes in resident's health status and documentation should include the date and time of fall.

Interviewed the Registered Staff and Resident Assessment Instrument (RAI) Coordinator and they confirmed the care plan was not updated to reflect Resident #11 most recent fall on April 4, 2014. [s. 8. (1) (a),s. 8. (1) (b)]

2. On April 12, 20, 25, 30, 2014, the clinical record indicated that Resident #8 had fallen and did not sustain any injuries. Upon further review of the documentation, the date of the fall was not updated in their care plan as per the home's policy. The care plan indicated that their last fall was February 17, 2014.

The home's Fall Management Program stated that Registered Staff were to update resident's care plan to reflect the changes in resident's health status and documentation should include the date and time of fall.

Interviewed the Registered Staff and Resident Assessment Instrument (RAI) Coordinator and they confirmed the care plan was not updated to reflect Resident #8's four falls during the month of April 2014. [s. 8. (1) (a),s. 8. (1) (b)]

3. On April 22, 2014 the clinical record indicated that Resident #2 sustained an unwitnessed fall in their room. Upon further review of the documentation, the date of the fall was not updated in their care plan as per the home's policy. The care plan indicated that their last fall was in 2011.

The home's Fall Management Program stated that Registered Staff were to update resident's care plan to reflect the changes in resident's health status and documentation should include the date and time of fall.

Interviewed the Registered Staff and Resident Assessment Instrument (RAI)

Coordinator and they confirmed the care plan was not updated to reflect Resident #2's most recent fall on April 22, 2014. [s. 8. (1) (a),s. 8. (1) (b)]

4. On April 22, 2014, Resident #2 sustained an unwitnessed fall and the clinical record revealed that a Physiotherapist post-falls assessment was not completed. A progress note was completed by the Physiotherapist on April 29, 2014 in regards to problems with the wheelchair but there was no documentation that an assessment was completed post fall.

The home's Falls Management Program indicated that the Physiotherapist was to assess residents post fall and implement interventions to prevent further falls.

On May 7, 2014 interviewed Registered Staff and confirmed that the Physiotherapist did not complete a post falls assessment after Resident #2 fell. Interviewed the Director of Care and confirmed that it was the home's expectation that the Physiotherapist should have completed a post falls assessment on all residents upon the Physiotherapist's next scheduled work day. [s. 8. (1)]

5. On February 27, March 28, April 12, 20 2014, Resident #8 fell. Reviewed the clinical record and a post falls assessment was not consistently completed by the Physiotherapist. The Physiotherapist did document in the progress notes after Resident #8 fell on April 25, 30, 2014 but the assessment was not completed after every fall that the resident sustained.

The home's Falls Management Program indicated that the Physiotherapist was to assess residents post fall and implement interventions to prevent further falls.

On May 7, 2014, interviewed Registered Staff and confirmed that the Physiotherapist did not complete a post falls assessment after each Resident #8 fall. Interviewed the Director of Care and confirmed that it was the home's expectation that the Physiotherapist should have completed a post falls assessment on all residents upon the Physiotherapist's next scheduled work day. [s. 8. (1)]

6. On April 4, 2014, Resident #11 fell in their room and the clinical record was reviewed and a post fall assessment was not completed by the Physiotherapist. On May 7, 2014 interviewed Registered Staff and confirmed that the Physiotherapist did not complete a post falls assessment after Resident #11 fell.

The home's Falls Management Program indicated that the Physiotherapist was to assess residents post fall and implement interventions to prevent further falls.

Interviewed the Director of Care and confirmed that it was the home's expectation that the Physiotherapist should have completed a post falls assessment on all residents upon the Physiotherapist's next scheduled work day [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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that use of a Personal Assistance Service Device (PASD)under subsection 3, to assist a resident with a routine activity of living, was included in the resident's plan of care.

On April 30, May 1, 2, 6-8, 2014, Resident # 6 was observed sitting in a tilt wheelchair.

On May 6, 2014, Registered Staff and the Resident Assessment Instrument (RAI) Coordinator were interviewed and they stated that Resident #6 was seated in a tilt wheelchair to improve their posture, positioning and comfort. They each confirmed that Resident #6 was using a tilt wheelchair as a PASD and that a PASD/Restraint Assessment was not completed.

On May 8, 2014 observed a Personal Support Worker (PSW) tilt Resident #6 wheelchair fully upright for the resident to eat breakfast and later tilt the wheelchair

back approximately thirty degrees when they attended an activity.

PSW was interviewed and confirmed that resident #6 was repositioned every two hours and that the resident used a tilt wheelchair to improve their posture and positioning.

Review of the clinical record revealed that there was no assessment or documentation for the use of the tilt wheelchair as a PASD and there was no consent documented from the resident or substitute decision maker (SDM) for the use of the PASD.

Registered Staff confirmed there was no consent from Resident #6 or their SDM for use of the PASD.

Registered staff stated that none of their tilt wheelchairs have been assessed to determine if they are being used as a PASD. [s. 33. (3)]

2. On April 30, May 1, 2, 6-8, 2014, Resident #1 was observed sitting in a Geri chair.

On May 6, 2014, Registered Staff and the Resident Assessment Instrument (RAI) Coordinator were interviewed and they stated that Resident #1 was seated in a Geri chair to improve their positioning, posture and comfort. They each confirmed that Resident #1 was using a Geri chair and that a PASD/Restraint Assessment was not completed.

On May 8, 2014, observed a Personal Support Worker(PSW) tilt Resident # 1's Geri chair upright for the resident to eat breakfast and later tilt the wheelchair back approximately thirty degrees when they attended an activity.

On May 8, 2014, PSW was interviewed and confirmed that resident #1 was repositioned every two hours and that the resident was seated in a Geri chair to improve their posture, positioning and comfort.

Review of the clinical record revealed that there was no assessment or documentation for the use of the Geri chair as a PASD and there was no consent documented from the substitute decision maker (SDM) for the use of the PASD.

Registered Staff confirmed there was no consent from Resident #1 SDM for use of the PASD. [s. 33. (3)]

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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, foods being served at a temperature that is both safe and palatable to residents.

A) During Stage 1 of the Resident Quality Inspection, resident #11 reported that the soup was sometimes cold, and resident #13 reported the food at times was cold.

B) During lunch service on May 1, 2014, resident #200 had a peameal sandwich and reported they would have preferred the sandwich served at a hotter temperature.

C) During lunch service on May 1, 2014, regular texture peameal bacon in the steam table was probed and measured at a temperature of 49.2 degrees Celsius. The home's temperature record log stated acceptable serving temperature for meat portioned for serving was 74 degrees Celsius or above. The Food Service Supervisor confirmed that meat portioned for serving was expected to be held at a temperature of 74 degrees Celsius or above for the duration of meal service.

D) During lunch service on May 1, 2014, pureed texture peameal bacon in the steam table was probed and measured at a temperature of 54.4 degrees Celsius. The home's temperature record log stated acceptable temperature for hot pureed foods was to be served at a temperature of 60 degrees Celsius or above. The Food Service Supervisor confirmed that hot pureed foods were to be held at a temperature of 60 degrees Celsius or above through the duration of meal service.

E) During lunch service on May 2, 2014, regular texture chicken vegetable soup in the steam table was probed and measured at a temperature of 79.1 degrees Celsius. The home's temperature record log stated the acceptable temperature for broth soups was 82 degrees Celsius or above. The Food Service Supervisor confirmed that broth soup was expected to be held at a temperature of 82 degrees Celsius or above through the duration of meal service.

F) During lunch service on May 6, 2014, regular and minced texture fish in the steam table was probed at a temperature of 71.2 degrees Celsius. The home's temperature record log stated acceptable serving temperature for meat portioned for serving was 74 degrees Celsius or above. The Food Service Supervisor confirmed that meat portioned for serving was expected to be held at a temperature of 74 degrees Celsius or above for the duration of meal service. [s. 73. (1) 6.]

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 be implemented voluntarily.

WN #4: 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. (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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other 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.

On May 2, 2014 resident #2 had a care plan that included an intervention to avoid large amounts of leafy green vegetables, other dietary sources of vitamin K created by a Registered Nurse.

The home's resident diet list for kitchen staff did not include the dietary intervention for resident #2.

On May 6, 2014, the Registered Dietitian reported that the documented intervention for resident #2 to avoid large amounts of leafy green vegetables, other dietary sources of vitamin K was not necessary for them. [s. 6. (4) (b)]

2. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

During Stage 1 in the Resident Quality Inspection, resident #9 stated that sometimes staff come in their room and do not say who they are or what they are doing.

Resident #9 reported an occurrence in the evening of May 1st, 2014 where they rang their call bell to receive assistance. Resident #9 reported a person entered their room and came to the bedside. The resident asked who the person was, and the person responded a verbal refusal to identify who they were.

Resident #9 had a plan of care stating all staff to identify self to resident before speaking/touching resident.

On May 6, 2014 at 12:28 hours, Inspector #585 observed Personal Support Worker enter resident #9's room and offered assistance to the dining room. The Personal Support Worker did not identify who they were before speaking with resident #9.

On May 6th, 2014, Inspector #585 observed second Personal Support Worker approach resident #9 at 13:26 hours face-to-face and asked if the resident wanted assistance with toileting. Inspector #585 later observed the same Personal Support Worker approach resident #9 at 13:31 hours from behind in the hallway and asked resident #9 if they could push them ahead in their wheelchair. In both observations, the Personal Support Worker did not identify who they were before and while speaking with resident #9.

The Personal Support Worker confirmed they had not always identified self to resident #9 when interacting, and the home's expectation was to introduce self to resident when interacting with the resident.

Interview with a Registered Nurse who stated they did not always identify who they were to resident #9 when interacting with them. Registered Nurse confirmed the resident's care plan was current as of May 6, 2014. [s. 6. (7)]

3. The licensee failed to ensure the care plan set out in the resident's plan of care was provided as specified in the plan.

Resident # 201 had a plan of care to receive full assistance with feeding at mealtimes.

On April 29, 2014 at 12:56 hours, Inspector #581 observed resident # 201 in the dining room with their meal placed in front of them with no staff present to assist them. Resident # 201 was not observed by Inspector #581 to receive full assistance from a Personal Support Worker until 13:10 hours.

Another Personal Support Worker reported on May 8, 2014 to Inspector #585 that the home's expectation was for Personal Support Worker's to provide full assistance to residents with feeding immediately after their meal being served.

On May 6, 2014, a Registered Nurse confirmed to Inspector #585 the home's expectation was for Personal Support Workers to assist residents who require full assistance as soon as they are served, and that resident #201 required full assistance with feeding at mealtimes.

The home's policy (LTC 09-05.06.03) Meal Service – Dining Room Responsibilities – Personal Support Worker (PSW) effective May 3, 2013 stated that meals or drinks should not be served to any residents who require assistance with eating or drinking until a staff is available to provide assistance. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home convened semi-annual meetings to advise such persons of the right to establish a Family Council.

On May 7, 2014 at 14:00 hours interviewed the Supervisor of Activation Services and they stated that they have not been convening meetings to encourage families to establish a Family Council semi-annually.

The last time a meeting was held to encourage the establishment of a Family Council was on January 22, 2013.

Observed the Family Council board and there was no posting to encourage family members to establish a Family Council in the home.

Reviewed the home's newsletters for the past year and there was no information shared in the newsletter to inform and advise family members of their right to establish a Family Council. [s. 59. (7) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food in the food production system were served using methods to prevent contamination.

On May 2, 2014 during lunch meal service, a dietary staff member was plating garlic bread and sausage buns with their bare hands.

The dietary staff was observed to touch their face multiple times and continued to touch the garlic bread and sausage buns without washing hands between actions. Interview with the dietary staff who reported the home's hand hygiene expectation of staff was to wash hands after touching their face when plating menu items with bare hands.

The Cook and Food Service Supervisor confirmed the home's hand hygiene expectation of staff was to wash hands after touching their face when plating menu items with bare hands. [s. 72. (3) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented in accordance with prevailing practices, for cleaning and disinfection of resident care equipment including shower chairs.

On April 30, 2014 between 1215 hours and 1630 hours, feces was observed on multiple occasions on both foot rests of a shower chair in tub room 2.

A non-nursing staff observed and confirmed the presence of feces on the foot rests and reported Personal Support Workers were responsible to disinfect the shower chair including the foot rests immediately after use with a resident.

Two residents were documented to receive showers with a Carino shower chair during the day on April 30, 2014. A Registered Nurse stated that additional residents may also receive a shower as per need. On May 7, 2014 a Personal Support Worker reported shower chairs were sometimes rotated between shower room 2 and tub room 2.

On May 6th, 2014 a Personal Support Worker and Registered Nurse confirmed the home's expectation was for Personal Support Workers to disinfect and scrub all contact surfaces of all shower chairs, including the foot rests after use with each resident.

On May 7, 2014, the Program Support Nurse confirmed the home's expectation that Personal Support Workers were responsible to disinfect and scrub all contact surfaces of a shower chair, including the foot rests after use with a resident. [s. 87. (2) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee did not ensure that a drug record was maintained, in which the following information was recorded in respect of every drug that was ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home

The drug record book was reviewed on May 2, 2014.

For the month of April 2014 there were five medications that were ordered and faxed to the pharmacy and when received they were not signed or dated by Registered Nursing staff.

Four medications that were ordered for the emergency box were not signed and dated when received by Registered Nursing staff.

Two medications were ordered and faxed to the pharmacy and the signatures and dates of when they were ordered and received by Registered Nursing staff were missing.

Registered Nurse confirmed that these medications were received from the pharmacy but Registered Nursing staff must have forgotten to sign and date the drug record book. Registered Nurse reported that it was an expectation of Registered Nursing staff to sign and date the drug record book when ordering and receiving medications. [s. 133.]

Issued on this 10th day of June, 2014

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