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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
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Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2018	2018_760527_0015	017169-18	Resident Quality Inspection

Licensee/Titulaire de permis

Peel Housing Corporation
10 Peel Centre Drive Suite B, 4th Fl. 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

KATHLEEN MILLAR (527), AMANDA COULTER (694), FARAH_ KHAN (695)

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 17, 18, 19, 20, 23, 24, and 25, 2018.

Dates inspection completed on: July 17, 18, 19, 20, 23, 24, and 25, 2018.

The following Critical Incidents (CIS) were inspected:
Log #017602-17, related to a fall
Log #017604-17, related to a fall
Log #020882-17, related to alleged staff to resident abuse
Log #022894-17, related to resident to resident sexual abuse
Log #025345-17, related to resident to resident sexual abuse
Log #021300-17, related to a bruise of unknown cause
Log #008901-18, related to a fall
Log #017033-18, related to a fall
Log# 002755-18, related to alleged staff to resident sexual abuse
Log #001041-18, related to resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisor of Activation and Volunteers, Supervisor of Facility Services, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Medical Pharmacies staff, Physiotherapist (PT), Maintenance technician, President of Resident Council, a Family Council member, Adult Day Program staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal incident reports, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **3 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure safe transferring and positioning devices or techniques when assisting the resident.

Resident #007 had a fall on a specific date in 2018. The resident was assessed and transferred to the hospital for further treatment.

The clinical record was reviewed and the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and the plan of care identified the resident's required needs for activities of daily living.

Personal Support Worker (PSW) #115 was interviewed and acknowledged that they provided care to the resident when the resident fell. The PSW acknowledged they did not check the plan of care and turned the resident without assistance.

PSW #112 was interviewed and they were on duty at the time of the incident. The PSW said that they were expected to know what was on the plan of care for resident #007 and implement the care for activities of daily living as directed in the plan.

Registered Nurse (RN) #101 was interviewed and was on duty at the time of resident #007's fall. The RN said that the PSWs were expected to check the care plan or kardex to ensure they knew the needs and preferences of the residents when providing care. The RN acknowledged that resident #007 did not receive the care as directed on the plan of care.

The licensee failed to ensure that safe positioning for resident #007, when providing care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #017033-18, conducted concurrently during the RQI.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On a specific date and time in July 2018, Long-term Care Home (LTCH) Inspector #527 observed an unmonitored and unlocked medication cart in the hallway. The Inspector was able to open all the drawers in each cart and observed medical supplies, medication, and personal health information of residents who lived on these units. In addition, there were medications left on top of the cart.

Residents that were cognitively impaired were wandering the hallway in their wheelchairs and some with walkers.

A review of the licensee's policy titled, "Medication - Administration - General", number LTC9-05.12.01, and last reviewed May 2015, directed registered staff to never leave the unlocked medication cart unattended or medications and/or electronic medication administration record system (eMARS) information unattended.

Registered Practical Nurse (RPN) #120 was interviewed and acknowledged that the medication cart was unlocked, out of their sight and that the medications were not secured. The RPN identified that a staff member from their contracted service used the medication cart last.

Pharmacy Technician #121 was interviewed and they acknowledged that their pharmacy staff were working on the medication cart. The Pharmacy Technician confirmed that the medication cart should have been locked.

Registered Nurse #113 was interviewed and they acknowledged that their medication carts should be locked at all times when not in use or when not in sight of the registered staff.

The licensee failed to ensure that drugs and drug-related supplies were secure and locked.

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) drugs are stored in an area or a medication cart, (ii) that is secure and locked, to be implemented voluntarily.

WN #3: 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. (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 :

The licensee failed to ensure the plan of care was reviewed and revised when the residents care needs changed.

(i) The written plan of care was updated and stated that resident #006 had specific dental needs at night. Resident #006's Point of Care (POC) documentation also indicated that the resident specific dental needs at night.

Resident #006 was observed on a specific date/time eating lunch. Both PSW #108 and PSW #107, in separate interviews, indicated that resident #006's dental needs changed in the past couple of months. PSW #107 acknowledged that the written plan of care was where they would expect to find the residents current dental care needs.

Registered Nurse (RN) #117 indicated that resident #006's dental care needs had changed for a while, but could not remember how long. The RN acknowledged that the written plan of care was inaccurate as it led staff to believe that resident #006's dental needs had not changed. The RN confirmed that the written plan of care should have

been updated when the residents’ dental care needs changed.

Resident Assessment Instrument - Minimum Date Set (RAI-MDS) Coordinator #118 also acknowledged that resident #006's dental care needs changed and that the plan of care stated the opposite. The RAI Coordinator acknowledged that the written plan of care should have been updated when the resident's dental care needs changed.

(ii) Resident #006 was assessed for a tilt wheelchair Personal Assistive Support Device (PASD) for comfort and repositioning.

The clinical record was reviewed and the POC documentation for May 2018, revealed that PSWs documented the use of the mobility device starting a specific date in May, 2018.

Resident #006 was observed in their mobility device in the lounge on two occasions.

Personal Support Worker #107 and RN #117, in separate interviews, acknowledged that they were aware that resident #006 had a specific mobility device. Registered Nurse #117 also acknowledged that this should be in the written plan of care for the resident.

The RAI-MDS Coordinator #118 acknowledged when the specific mobility device was implemented and that it was not in the written plan of care, and should have been.

The licensee failed to ensure that resident #006’s plan of care was reviewed and revised when the resident no longer wore their dental needs changed and when they started using a specific mobility device.

Issued on this 7th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), AMANDA COULTER (694), FARAH_ KHAN (695)
Inspection No. / No de l'inspection :	2018_760527_0015
Log No. / No de registre :	017169-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2018
Licensee / Titulaire de permis :	Peel Housing Corporation 10 Peel Centre Drive, Suite B, 4th Fl., BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	Vera M. Davis Community Care Centre 80 Allan Drive, Bolton, ON, L7E-1P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Liezle Trinidad

To Peel Housing Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36

Specifically, the licensee shall ensure that:

1) Staff shall provide safe transferring, positioning devices or techniques when assisting resident #007 and any other residents as directed in their plan of care.

Grounds / Motifs :

1. The licensee failed to ensure safe transferring and positioning devices or techniques when assisting the resident.

Resident #007 had a fall on a specific date in 2018. The resident was assessed and transferred to the hospital for further treatment.

The clinical record was reviewed and the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and the plan of care identified the resident's required needs for activities of daily living.

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The licensee failed to ensure that safe positioning for resident #007, when providing care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #017033-18, conducted concurrently during the RQI.

2) The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident of the home. The home had a level 4 history as there was an order within the last 36 months and non-compliance continues with this section of the LTCHA that included:

- Compliance order issued January 4, 2017, (2017_570528_0001) (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Central West Service Area Office