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 prévue 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

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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 27, 2019	2019_787640_0006	024615-18, 004147-19	Complaint

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

HEATHER PRESTON (640)

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 21 and 22, 2019.

This inspection was conducted in conjunction with Critical Incident (CI) inspection #2019_787640_0005.

The following Complaint reports were included in the inspection;
Log #024615-18 related to a complaint regarding resident care.

The following Critical Incident reports were included in the inspection:
Log #004147-19 which was related to Log #024476-18 related to alleged resident to resident physical abuse

PLEASE NOTE: Written notification related to Long Term Care Homes Act, 2007, s.23 (2) was identified in a concurrent inspection #2019_787640_00005 (Log #009675-18)

During the course of the inspection the Long Term Care Homes (LTCH) Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision makers (SDM), Personal Support Workers (PSW), Registered Nurses (RN), Physiotherapist (PT), Behaviour Support Ontario Registered Practical Nurse (RPN), restorative care PSW and the Director of Care.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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. 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee was immediately investigated.

On an identified date and time in August 2018, staff found resident #004 with a pillow and blanket placed over their face.

The investigative records and the clinical record for resident #004 noted that the investigation began three days after the incident occurred.

The DOC told the Long Term Care Homes (LTCH) Inspector they had not initiated the investigation immediately as the staff member who had observed and reported the incident to the nurse, was not working until then.

The licensee failed to ensure an investigation was immediately initiated for an alleged incident of abuse of a resident. [s. 23. (1) (a)]

2. The licensee failed to ensure that the results of the investigation of alleged abuse of a resident, was reported to the Director.

On an identified date in May 2018, resident #003 received unwanted advances by a male client.

The Critical Incident Report (CIR) was reviewed by the LTCH Inspector and it had not been amended to reflect the results of the investigation and the outcome of the incident.

The DOC acknowledged the CIR related to alleged abuse of resident #003 had not been amended as required.

The licensee failed to ensure the CIR was amended to reflect the results of the investigation of the alleged abuse. [s. 23. (2)]

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 the licensee must ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, that the suspicion and the information upon which it was based, was immediately reported to the Director.

On an identified date and time in August 2018, staff found resident #004 with a pillow and blanket placed over their face.

PSW #104 immediately reported the incident to RN #111. The DOC was made aware of the incident the same date as the occurrence.

The LTCH Inspector reviewed the CIR and the clinical records of residents #004 and #005 which indicated the incident was reported to the Director over three days after the alleged incident of abuse of a resident.

The licensee failed to ensure that the Director was immediately notified of the suspected abuse of the resident #004. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker (SDM), was notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of a resident.

On an identified date and time in August 2018, staff found resident #004 with a pillow and blanket placed over their face.

Resident #004's SDM told the LTCH Inspector they had not been notified of the incident until they had called in on a different matter.

The LTCH Inspector reviewed the clinical records of resident #004 and noted they did not reflect notification of the SDM.

The DOC acknowledged that resident #004's SDM was not notified within 12 hours of the incident.

The licensee failed to ensure that the SDM of resident #004, who were allegedly abused by anyone, was notified within 12 hours of the incident. [s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

On an identified date and time in August 2018, staff found resident #004 with a pillow and blanket placed over their face.

Resident #004's clinical record identified the OPP were notified three days following the incident.

The DOC aknowledged that they had informed the OPP over three days following the alleged incident of abuse of a resident.

The licensee failed to ensure the appropriate police force was immediately notified of the alleged abuse of resident #004. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to a staff member concerning the care of a resident or operation of the home was dealt with including investigation, and being resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

On an identified date and time in August 2018, staff found resident #004 with a pillow and blanket placed over their face.

Resident #004's SDM informed RN #109, that the interventions put in place to ensure there were no further incidents, had not occurred during the time the SDM had been visiting that day.

RN #109 informed the SDM they would inform the DOC for the DOC to follow up. The RN documented same in the progress notes of the resident's clinical record.

The home's policy "Reporting and Managing Complaints and Recommendations", policy #LTC1-05.05, with a revised date of April 26, 2017, directed staff to complete the "LTC Complaint or Recommendation Form" for every verbal complaint, unless resolved within 24 hours.

RN #109 told the LTCH Inspector they recalled they had sent an email to the DOC regarding the concern brought forward. They had no clear recall whether they had completed the form as per the home's policy.

The DOC told the LTCH Inspector they did not receive an email or a complaint form containing the concern from resident #004's SDM regarding the interventions implemented related to the incident that occurred three days earlier.

The SDM told the LTCH Inspector they felt the home had not taken their concern seriously as they had not been contacted by the home regarding the incident and the concern shared with the RN.

The licensee failed to ensure the verbal complaint was investigated, resolved and a response provided to the complainant within 10 business days of the receipt of the complaint. [s. 101. (1) 1.]

Issued on this 28th day of February, 2019

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

Original report signed by the inspector.