Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Original Public Report

Report Issue Date: May 2, 2023	
Inspection Number: 2023-1229-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Peel Housing Corporation	
Long Term Care Home and City: Vera M. Davis Community Care Centre, Bolton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.05.03 14:52:28 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on April 12-14, and 18-21, 2023, and offsite on April 17, 2023.

The following intake(s) were inspected:
- Intake #00017080, related to falls prevention and management
- Intake #00019085, related to Residents' Bill of Rights
- Intake #00083934, related to alleged abuse
- Intake #00020014, a complaint related to falls prevention and management and resident safety.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure that a resident's privacy was afforded when caring for their personal needs.

Rationale and Summary

A resident had specific strategies in their plan of care to respond to their personal care needs.

On two separate occasions, while attempting to use one of the strategies to provide care to the resident, a staff member did not ensure the resident's privacy was maintained.

The resident's personal information and personal health information were inappropriately shared.

The Director of Care (DOC) said sharing the resident's personal information without consent was a breach of the resident's rights to privacy and dignity.

By sharing the resident's personal information and personal health information without consent, there was a breach of the resident's privacy.

Sources: a critical incident report, a resident's clinical records, the home's investigative notes, the home's policies related to the use of social media and personal cellular or electronic communication devices and interviews with a PSW, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were identified and implemented to respond to a resident's responsive behaviour.

Rationale and Summary

A resident had a specific responsive behaviour which posed a risk of harm to the resident.

On one occasion, the resident displayed the specific behaviour and staff members were not able to respond to the resident in a timely manner.

The resident was found injured and there was a change in their condition.

The home's Behavioural Supports Ontario (BSO) Nurse and an RN said the resident's responsive behaviour was unpredictable and put the resident at risk of harm.

In a nine month-period prior to the incident, the resident displayed the specific responsive behaviour on three separate occasions. The resident's plan of care did not include any strategies to manage the resident's specific behaviour and minimize the risk of harm to the resident. Additionally, there was no documentation of the resident's Substitute Decision Maker's (SDM) involvement in the resident's plan of care in relation to the resident's specific responsive behaviour.

The home's BSO Nurse and the DOC said safety concerns should have been discussed with the resident's family and interventions to manage the resident's responsive behaviour should have been identified and implemented.

Not identifying and implementing strategies to manage the resident's responsive behaviour posed a risk to the resident's safety as staff were unable to intervene in a timely manner to mitigate the risk of harm to the resident.

Sources: a critical incident, a resident's clinical records, the home's investigative notes and interviews with an RN, the BSO Nurse, DOC and other staff. [758]