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

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Original Public Report

Report Issue Date: August 20, 2024
Inspection Number: 2024-1229-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Peel Housing Corporation
Long Term Care Home and City: Vera M. Davis Community Care Centre, Bolton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 22-25, 29-31, and August 1-2, 2024

The following intake was inspected:

- Intake #00121591, related to a Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident's dietary needs changed, their plan of care was reviewed and revised.

Rationale and Summary

A resident's plan of care documented the resident needed assistance with eating and a specific feeding aide.

One occasion, during a meal service, the resident ate independently and was not

provided with the specific feeding aide. On two separate occasions the resident was provided with two feeding aides that were not included in their plan of care.

The Registered Dietitian (RD) said the resident needed different feeding aides depending on their feeding abilities and the resident's plan of care should have been updated to include this information.

By not reviewing the resident's plan of care when their dietary needs changed, there was a risk that staff may not provide the required interventions consistently.

Sources: observations of lunch meal services, a resident's medical records, and interviews with the RD and other staff.

Date Remedy Implemented: July 24, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (1)
Posting of information
s. 85 (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary

During a tour of the home, an information board located in the medication room contained information related to the duty to make mandatory reports and the Policy

to promote zero tolerance of abuse and neglect of residents.

The Director of Care (DOC) stated that this information was not accessible to all staff but should be.

Two days later, it was observed that the above information was posted in the bulletin board on each nursing station.

Sources: Observations and interviews with staff.

Date Remedy Implemented: July 24, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (f)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints;

The licensee failed to post the written procedure and contact information for making complaints to the Director regarding the Ministry Family Support and Action Line.

Rationale and Summary

The Long-Term Care Homes (LTCH) Inspector observed that the written procedure and contact information for making complaints to the Director was not posted in the home.

The DOC said that this document should have been posted publicly.

Two days later, the LTCH Inspector observed this document posted on the bulletin board at the front entrance of the home.

Sources: two observations, and an interview with the DOC.

Date Remedy Implemented: July 24, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the written record of two of the home's annual program evaluations included the dates when changes to the programs were made.

Rational and Summary

The home's annual evaluations of two mandatory programs did not include the dates when changes to improve resident outcomes were implemented.

The DOC said the above dates should have been documented on the evaluation of the programs.

Sources: the home's two annual program evaluations, and interviews with the DOC and other staff.

Date Remedy Implemented: August 2, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 23.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
23. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

The licensee failed to ensure that resident's right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible was upheld.

Rationale and Summary

Several residents reported that they were no longer able to independently operate the overbed lights when the home replaced the light switch pull cord with a dimmer on the wall.

The DOC said that not being able to independently operate the overbed light would limit residents' independence.

Some residents were impacted when they were not able to independently operate their overbed light.

Sources: observations, residents' council meeting minutes, and interview with the DOC and others.

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that a resident's plan of care related to dietary needs was followed.

Rationale and Summary

A resident was observed being assisted to drink using a specific feeding aide that

was not indicated in their plan of care.

By staff not following the resident's plan of care related to the use of assistive feeding aids, there was a risk the resident may not tolerate well the fluids when using the specific feeding aide.

Sources: observation of a meal service, a resident's plan of care, progress notes, and interviews with the RD, and DSS.

WRITTEN NOTIFICATION: Residents' Council

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that responses to the Residents' Council concerns and recommendations related to the operation of the home were provided in writing within 10 days of receiving them.

Rationale and Summary

The home's Residents' Council meeting minutes over one year period documented multiple concerns and recommendations related to the operation of the home.

There was no documentation to indicate that the responses to the above concerns and recommendations were provided in writing within 10 days of receiving them.

By not providing a response in writing within 10 days from receiving the concerns and recommendations of the Residents' Council, the council members were unsure when and if a follow up was completed and may be dissatisfied with the process.

Sources: the home's Resident Council meeting minutes, and an interview with the Supervisor of the RSS.

WRITTEN NOTIFICATION: Family Council

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to respond to the concerns and recommendations of the Family Council in writing within 10 days of receiving them.

Rationale and Summary

The Family Council's meeting minutes in one year period, documented multiple concerns and recommendations related to the operation of the home.

There was no documentation to indicate when a response to the above concerns and recommendations was provided to the Family Council.

By not providing a response in writing within 10 days from receiving the concerns related to the operation of the home, the Family Council was not aware when their concerns were followed up on and the outcome and might have decreased their satisfaction with the home's follow up process.

Sources: the home's Family Council meetings minutes, and an interview with the Administrator and others.

WRITTEN NOTIFICATION: Doors in a home

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas were closed and locked when not supervised by staff.

Rationale and Summary

A LTCH Inspector observed three doors leading to non-residential areas were not closed all the way or locked on two separate occasions.

The DOC stated that these doors should always be locked to minimize risk to residents.

Sources: observations of the doors in two RHAs, and an interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

The licensee has failed to comply with the procedure related to the treatment of pressure injuries for two residents.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their skin and wound care program includes treatment and interventions for wounds and is complied with.

Rationale and Summary

The home's Skin and Wound Care policy documented that for the management of residents with specific pressure injuries staff were to refer to Wound Protocol Appendix F. If the Enterostomal Therapy (ET) or Wound Care Nurse provided recommendations, a physician's order was to be obtained for the treatment. If the

wound presented signs or symptoms of infection, the physician was to be notified immediately, and an order obtained to treat the infection.

The Wound Care Protocol in Appendix F documented that staff were to consult with the attending physician, the Nurse Practitioner and Wound Care Nurse for the treatment of a specific pressure injuries. Additionally, the wound protocol documented specific treatments to be applied to the pressure injuries and if there was no improvement, the physician, Nurse Practitioner (NP), Wound Care Nurse or ET nurse were to be informed. Registered nursing staff were to ensure the documentation of the wound plan of care was completed.

A. A resident had a pressure injury and staff applied different treatments than described in the home's protocol without informing the physician and obtaining an order. Additionally, when the ET nurse made recommendations, no physician's order was obtained for the treatment.

The resident had a second pressure injury and the treatment applied was not documented as required in the home's policy.

The DOC and the Skin and Wound Care Lead acknowledged the gaps in following the home's wound care protocols for the resident's pressure ulcers.

Sources: a resident's clinical records, the home's skin and wound care program, and interviews with the home's Skin and Wound Care Lead and the DOC.

B. A resident had a pressure injury and the treatment provided was different from the home's protocol. There was no documentation that the physician was notified about this treatment.

Approximately one month later, the wound started to deteriorate, and the treatment had to be changed.

By not following the wound treatment protocols as indicated in the home's skin and wound care policy, staff were not applying the appropriate treatment consistently which may have contributed to the wound deterioration.

Sources: a resident's clinical records, the home's skin and wound care program, and interviews with an RN, the home's Wound Care Lead and the DOC.

WRITTEN NOTIFICATION: Menu planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the home's evaluation of the menu cycle for 2023-2024, included a summary of the changes made to the menu and the date the changes were implemented.

Rationale and Summary

The home's evaluation of the menu cycle 2023-2024, did not include a summary of the changes made to the menu and the dates when those changes were implemented.

By not including the changes made to the menu cycle and the dates when the

changes were implemented, it made it difficult to keep track of the menu changes and evaluate the outcomes of these changes.

Sources: the home's menu cycle evaluation for 2023-2024, and an interview with the DSS.

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that their dining service procedures to ensure food and fluids were served at a temperature that was safe and palatable for the residents were complied with.

Rationale and Summary

The home's food temperatures policy and procedures related to food temperature provided specific guidelines for recording temperatures and what the safe temperatures were, depending on the type of food.

On two separate occasions, no temperatures were taken prior to serving the food at lunch to the residents in one of the Resident Home Areas (RHA).

The home's Food Temperatures and Leftovers Audit records for the above RHA in one-week period, showed that temperatures were either not taken at all required times, there were no times of the temperatures recorded, or the temperatures recorded were not within the guidelines. There was no documentation of any follow up actions taken.

The DSS acknowledged that food and fluids temperatures were not checked as required in the home's policies for the meals served on the specific RHA.

Staff not checking the food and fluids temperatures before being served as indicated in the home's policies posed a potential risk that the food served to the residents may not be at a safe or palatable temperature.

Sources: observations of the lunch meal service, the home's policy Food temperatures-production, hot holding cabinet and point of service, General Food production safety practices for dietary services department policy, Food Temperatures and Leftovers Audit records, and interviews with a Cook, a Dietary Aide, and the DSS.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,

i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the home's Continuous Quality Improvement (CQI) report for the last fiscal year included the dates when the actions taken to improve the long-term care home and the care, services, programs and goods based on the documentation of the results of the resident and family experience surveys, were implemented and the outcomes of these actions.

Rationale and Summary

The home's CQI report for the last fiscal year did not include the dates when actions were taken to improve the long-term care home based on the documentation of the results of the residents and family/caregiver experience surveys and the outcome of these actions.

The home's CQI Specialist and the CQI Lead acknowledged the above information was not included in the CQI report as required.

Failure to include the above required information in the home's CQI report was a missed opportunity to track and share the home's progress with residents and their families and staff.

Sources: the home's CQI report, and interviews with the home's CQI Specialist and the CQI Lead.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the home's CQI report for the last fiscal year included the dates when the actions taken to improve the accommodation, care, services, programs, and goods provided to the residents based on the home's priority areas for quality improvement were implemented and the outcomes of these actions.

Rationale and Summary

The home's CQI report for the last fiscal year did not include the dates when actions taken to improve the accommodation, care, services, programs, and goods provided to the residents based on the home's priority areas for quality improvement were implemented and the outcomes of these actions.

The home's CQI Specialist and the CQI Lead acknowledged the above information was not included in the CQI report as required.

Sources: the home's CQI report, and interviews with the home's CQI Specialist and the CQI Lead.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the home's CQI report for the last fiscal year included the dates when the actions taken to improve the long-term care home and the care, services, programs and goods based on the documentation of the results of the resident and family experience surveys were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

The home's CQI report for the last fiscal year did not include how, and the dates when, the actions taken based on the resident and family experience surveys and

on the home's priority areas for quality improvement were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

The home's CQI Specialist and the CQI Lead acknowledged the above information was not included in the CQI report as required.

By not including the above information in the home's CQI report, the home's progress could not be tracked and shared with residents and their families and staff.

Sources: the home's CQI report, and interviews with the home's CQI Specialist and the CQI Lead.