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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: January 28, 2025
Inspection Number: 2025-1229-0001
Inspection Type: Complaint Critical Incident
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: January 14-17, 20-24, 27, and 28, 2025.
The inspection occurred offsite on the following date: January 22, 2025

The following intakes were inspected:

- Intake# 00129641 regarding the resident's care and personal support services;
- Intake #00130651 and intake #00130798 regarding an allegation of resident neglect;
- Intakes #00136032 and intake #00129721, regarding the home's Infection Prevention and Management Program; and
- Intake #00136183 regarding concerns about the home's responsive behaviour program.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviors

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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to their elopement attempts.

A resident's care plan was revised to specify when the resident was at highest risk to elope.

Sources: a resident's clinical records and staff interviews.[753]

Date Remedy Implemented: January 17, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

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,

(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.

The licensee failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent and complemented each other.

The home's management team had a meeting regarding a resident's responsive behaviours and discussed interventions to implement.

The home's Behavioral Supports Ontario (BSO) leads said they were not present for the meeting and were not aware of the interventions implemented.

Sources: a resident's clinical records and interviews with staff. [753]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9)

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

a) The licensee has failed to ensure the provision of the care set out in the plan of care for a resident were documented.

A treatment administered to a resident was not documented by the registered staff who completed the treatment.

b) The licensee failed to ensure the provision of the care set out in the plan of care for a resident was documented.

An assessment that was completed by the Physiotherapist (PT) for a resident who had a fall was not documented in the resident's plan of care.

Sources: a resident's clinical records and interviews with staff. [753][606]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident immediately reported the suspicion and the information upon which it is based to the Director.

A critical incident report was not immediately submitted to the Director regarding a resident who had an injury of unknown cause.

Sources: a Critical incident report, resident's clinical records and interviews with staff. [753]

WRITTEN NOTIFICATION: Care Conference

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (c)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(c) a record is kept of the date, the participants and the results of the conferences.

A care conference was held with a substitute decision maker (SDM) regarding concerns about a resident's care. There was no record of the care conference.

Sources: a resident's clinical records and interviews with staff. [753]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident's area of altered skin integrity was reassessed at least weekly.

Weekly re-assessments of two residents to track the progression of healing of the altered skin integrity were not completed.

By failing to assess the resident' altered skin integrity at least weekly may prevent the opportunity to address changes in the skin impairment.

Sources: a resident's clinical records and interviews with staff. [606][753]

WRITTEN NOTIFICATION: Skin and Wound

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) when their fluid intake decreased.

A resident who had an altered skin integrity did not meet their daily fluid requirements and was not referred to the RD for reassessment.

By failing to refer the resident put the resident at risk of dehydration and further skin breakdown.

Sources: a resident's clinical records and interviews with staff. [606]