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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 30, 2013	2013_207147_0016	H-000380-13	Critical Incident System

Licensee/Titulaire de permis

PEEL HOUSING CORPORATION
10 Peel Centre Drive, Suite A, BRAMPTON, ON, L6T-4B9

Long-Term Care Home/Foyer de soins de longue durée

VERA M. DAVIS NURSING HOME
80 Allan Drive, Bolton, ON, L7E-1P7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 28, 2013

H-000380-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Supervisor of Care, Charge nurse and Environmental Manager.

During the course of the inspection, the inspector(s) reviewed the resident's clinical records, home's internal investigation notes, staff personnel file and policy and procedures related to Falls Prevention, Minimizing of Restraints and Prevention of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care was provided to resident #101 as specified in the plan.

Review of the resident #101 plan of care, Resident Assessment Protocol (RAP) for the past three quarters and interview with the staff indicated that the resident is a total mechanical lift, requires total assistance of two staff for all aspects of activities of daily living (ADL) and the bed to be at the lowest position while in bed for safety and falls prevention strategies.

Interview with the Registered Staff, Supervisor of Care and review of the home's internal investigation notes confirmed that in June 2013 two Personal Support Workers (PSW) initiated care for resident #101. While providing care, one PSW left to assist another resident while the second PSW continued to provide care for the resident. While providing care alone to the resident, the second PSW left the resident unattended, leaving the resident in an unsafe situation. While unattended, the resident fell out of bed and sustained an injury. [s. 6. (7)]

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 the care set out in the plan of care is provided to resident as specified in the plan, to be implemented voluntarily.

Issued on this 3rd day of September, 2013

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