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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2018	2018_748723_0004	027889-17, 009674-18, 020888-18, 020909-18	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Bloomington Cove Care Community
13621 Ninth Line Stouffville ON L4A 3C8

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

ADELFA ROBLES (723), MIKO HAWKEN (724), ROMELA VILLASPIR (653)

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): August 22, 23 and 24, 2018.

The purpose of this complaint inspection was related to care concerns of resident #001 and other residents in the home. The following Log #(s) submitted through the ACTIONLine were completed during this inspection:

Log#: 027889-17,
Log#: 009674-18,
Log#: 020909-18,

Log # 020888-18, related to improper care was completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Resident Programs and Admissions (DRPA), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation Therapist (RT), Receptionist/Staffing Coordinator (R/SC), Hair Stylist (HS), Personal Support Worker (PSW), Agency Personal Support Worker (APSW) and Housekeeper.

During the course of inspection the inspector(s) observed: meal and snack services, delivery of resident care and services including resident - staff interactions, conducted a review of relevant resident health records, home policies and procedures related to complaints, abuse and neglect, complaint response log and investigational notes, mandatory training records, staff work routines, unit assignment records, staffing plan, daily roster reports, staff sign in records and activity calendar.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee had failed to ensure that the following rights of residents were fully

respected and promoted: Every resident has the right to be cared for in a manner consistent with his or her needs.

The home submitted Critical Incident Report (CIR) on an identified date and time to the Director, for improper/ incompetent treatment of a resident. The CIR indicated that resident #001's Substitute Decision-Maker (SDM) had a concern regarding the care provided to the resident on an identified date and time.

The Ministry of Health and Long Term Care (MOHLTC) ACTION Line received a complaint on an identified date and time related to the care of resident #001, in the home. The concern was regarding a staff member who refused to provide care to resident #001. The complainant indicated that on an identified date one of the staff members refused to help the resident.

A review of resident #001's written plan of care with an identified date indicated that the resident required two staff for assistance.

A telephone interview with resident #001's SDM on an identified date and time indicated that resident #001, required two staff for assistance. On an identified date Personal Support Workers (PSWs) #107 and #122 attended to resident #001 at an identified time with the SDM present. PSW #107 returned after ten minutes, and stated that they could not find a second staff member to assist with the care, and then left the room. At an identified time, PSW#107 came back with PSW #105 who came from another home area, and both staff provided care to resident #001. The SDM further stated that they had spoken to the charge nurse regarding the refusal of the other two PSWs on the floor, to provide care to the resident.

A telephone interview with PSW #107 on an identified date and time revealed they were the primary PSW assigned to resident #001's care on an identified date. PSW #107 stated that at an identified time, they went to resident #001's room and asked the SDM if the resident was ready for care. The SDM said they were ready at that time. PSW #107 left the room and asked the assistance of PSWs #119 and #122, and both declined. PSWs #119 and #122 suggested to PSW #107 to ask PSW #105 from another home area to come to the floor and assist with resident #001. PSW #107 stated that RN #123 called PSW #105 from another home area, and PSW #107 went back to the resident's room and told the SDM they were still waiting for a staff member to assist them with resident #001. When PSW #107 was about leave the room, PSW #122 came to the room and provided assistance. PSW #119 confirmed that the delay in care occurred when they

could not find another staff member to help them resident #001.

An interview with PSW #119 on an identified date and time indicated that on an identified date they were scheduled to work. The PSW told RN #123 at the beginning of the shift that they do not provide care to resident #001's and that PSW #122 can provide the assistance instead. PSW #119 denied being asked to assist with resident #001's care on the identified shift and denied refusing to provide assistance to PSW #107.

A telephone interview with PSW #122 on an identified date and time indicated they worked on an identified date. The PSW denied refusing to provide assistance to PSW #107 on the identified shift.

The DOC acknowledged the above mentioned information from the interviews and record reviews, and indicated that the home's expectation was for staff to provide care to resident #001, and help one another when providing care to the resident as needed, and that no staff was to refuse care unless their safety was at risk.

Based on record reviews and staff interviews, resident #001, required two staff assistance. On an identified date and time the resident's primary PSW needed a second staff member to assist resident #001. PSW #107, indicated the other two PSWs declined. The PSW further indicated there was a minor delay in care in the beginning due to the other PSWs' refusal to provide assistance, thus, the licensee had failed to promote resident #001's right to be properly cared for in a manner consistent with their needs.

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 that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 :

The licensee had failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the ACTIONLine on an identified date regarding residents who required total care from staff were not getting out of their beds and would not receive their meals. The complainant identified that this issue was observed in an identified home area.

Inspector #724, conducted a review of clinical records for resident #008 and revealed that the resident was fully dependent and required extensive assistance. Resident #008 likes to be up at an identified time as per the written plan of care.

Inspector #724, conducted the following observations for resident #008:

-On an identified date and time PSW #112, brought the resident into the dining area in their wheelchair for meals. Meals had just started in the dining room.
-On an identified date and time resident was observed in the dining room for meals.
-On an identified date and time resident was on the bed.
-On an identified date and time resident still in their room. Meals had started in the unit.
-On an identified date and time PSW #114, brought meal tray inside resident room.

An interview was conducted by Inspector #724, with PSW #114, on an identified date and time and confirmed that on an identified date, resident #008, was observed on the bed at an identified time and that the meal tray was brought to the resident inside their room at an identified time. PSW #114, stated during the interview that they could not get resident #008, ready for meals in the dining room on an identified date since there was not enough time and assistance from other staff. PSW #114, also indicated that resident #008, would not be ready for meals and would have meals late at least three times per week. PSW #114, also revealed in the interview, that even if the unit was fully staffed, they would choose up to three residents who would get up later on their shift to delay care. PSW #114, also stated that the care set out in the written plan of care for resident

#008, was not followed when resident #008, was not up at an identified time as written in the plan and received meals late.

In an interview on an identified date with Registered Practical Nurse (RPN) #109, confirmed the above observations with resident #008, on an identified date and stated that it was not unusual for resident #008, to be absent from the dining room for meals since they required extensive assistance and there was not enough staff to assist with transfers. RPN #109, stated that this would happen at least once a week.

An interview was carried out by Inspector #724 with the DOC on an identified date, the DOC confirmed that it was an unacceptable practice for the staff to delay meals for resident #008. The DOC confirmed that the care set out in the written plan of care for resident #008 was not followed when resident was not up at an identified time as specified in the plan and received the meals late.

The licensee therefore failed to ensure that care set out in the plan of care for resident #008, was provided to the resident as specified in the plan.

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

WN #3: 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 :

The licensee had failed to 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 was dealt with as follows: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph three provided within ten 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.

The MOHLTC ACTIONLine received a complaint on an identified date and time related to the care of resident #001 in the home. The concern was in regards to a staff member refusing to provide care to resident #001. On an identified date one of the staff members refused to help the resident.

A telephone interview with resident #001's SDM on an identified date and time indicated that on an identified date they had spoken to RN #123, in regards to staff members refusing to provide care to the resident.

A telephone interview with RN #123, on an identified date and time revealed they were the charge nurse on an identified date. The RN indicated that resident #001's SDM had spoken to them and was upset the resident waited too long for assistance. The SDM questioned why a staff member from another home area had to come instead. RN #123, stated they called the DOC and reported the SDM's concern. The DOC told the RN to write down the concern on a piece of paper, bring it to their office, and the DOC will speak with the RN at a later time. RN #123, confirmed they wrote the concern on a piece of paper and slipped the paper underneath the DOC's door that evening.

A review of the home's investigation notes identified RN #123's letter to the DOC on an identified date indicating resident #001's SDM had spoken to them and was concerned about PSWs #119, and #122, not helping PSW #107, during the resident's care. The letter further indicated that PSW #105 came late and resident #001, had to wait too long for assistance.

An interview with the DOC on an identified date and time revealed that on the evening of an identified date RN #123, had called and informed them that resident #001's SDM was upset that they waited for so long for staff to come and questioned why a PSW from another home area had to come for the resident. When asked by the inspector regarding the instructions the DOC had provided to RN #123, the DOC stated they had asked the RN to write the concern on a sheet of paper and place it in their office. The DOC stated they had seen the RN's letter the morning of an identified date when they returned to the office. When asked by the inspector who was responsible for initiating the internal investigation based on the complaint received, the DOC indicated they were responsible to do the investigation in the above mentioned complaint that involved the nursing department. The DOC further indicated they had only initiated the investigation after their meeting with the SDM on an identified date when the SDM raised concerns.

The licensee had failed to 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 was dealt with as follows: The complaint shall be investigated and resolved where possible, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

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 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 three provided within ten 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, to be implemented voluntarily.

Issued on this 31st day of October, 2018

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

Original report signed by the inspector.