Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 18, 2016	2016_391603_0005	005301-14	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

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

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

SYLVIE LAVICTOIRE (603), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)

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): March 7-11, 14-18, 2016

This Complaint inspection is related to 19 complaints submitted to the Director. Log #005455-14, 005939-14, 007612-14, 004649-14, 016158-15, and 025126-15 related to allegations of abuse to a resident. Log #005346-15, 035466-15, and 007794-14 related to failure to comply. Log #000431-14, 004010-14, 014318-15, 022905-15, 007096-14, 030943-15, 005301-14, 000169-14, 003842-15, and 005660-14 related to allegations of improper care and harm to a resident.

A Critical Incident inspection related to 12 critical incidents submitted to the Director regarding allegations of abuse to a resident was conducted concurrently with this inspection. For details, see inspection #2016_391603_0006.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Director of Programs/Admissions, Director of Environmental Services, Pharmacist, Director of Dietary Services, Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Human Resources Manager, Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist, Physiotherapist Assistants, Housekeeping Staff, Food Service Assistants, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

9 WN(s)
4 VPC(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #603 reviewed a complaint submitted to the Director regarding improper care for resident #011 and insufficient staffing levels.

On a certain date at 1645hrs, Inspector #603 observed resident #011 ready to have dinner in the dining room. The resident had just had their scheduled bath and was dressed in their pyjamas.

An interview with PSW #101 revealed that the resident had just been bathed and dressed in their pyjamas instead of their regular clothes, because there was no time to change the resident again, before bedtime and that it was easier on the resident.

A review of the resident's current care plan revealed no interventions to dress the resident in their pyjamas at 1645hrs, nor was it indicated that the baths should be done before dinner time. [s. 6. (1) (c)]

2. Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #010. The complaint indicated concerns regarding continence care for this resident.

The Inspector reviewed the resident's health care record. Under the focus toileting, an intervention indicated that staff were to ensure the resident was cleansed using a specific spray. Under the focus hygiene, an intervention indicated that staff were to ensure that the resident was cleansed using soap and water.

A progress note indicated that the resident's Substitute Decision Maker requested the staff to use soap and water for the resident's pericare, and not a specific spray.

During an interview, RPN #121 indicated that the resident was on a toileting program and staff use soap and water to clean the resident and not a specific spray.

During an interview, PSW #122 indicated that the staff used a specific spray when the resident was incontinent of urine and used soap and water when the resident had a bowel movement. PSW #122 indicated that the staff were not aware that they were not supposed to use a specific spray.

During an interview, RPN #105 confirmed that the care plan did not provide clear directions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #010. The complaint indicated that upon admission, the resident was receiving specific medications in the morning which increased the resident's risk of falls.

During an interview, resident #010's Substitute Decision Maker (SDM) indicated that the resident was receiving two specific medication in the morning, however, these medications made the resident drowsy and that the SDM advised staff that the preferred timing of the medications was in the evening.

A review of the resident's health care record revealed that the resident was admitted to the home on a specific day. The Medication Administration Record indicated that the specific medications were given at 0800 hours on the next two days.

During an interview, the Director of Care indicated that the SDM reviewed the medications upon admission with the pharmacy, advising of the preferred medication times. [s. 6. (2)]

4. The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Inspector #575 reviewed a complaint regarding resident #003 which indicated the resident had a fall.

The Inspector reviewed the resident's health care record that revealed on a certain date, the resident had a fall and sustained three injuries. The post fall assessment did not include the notification of the resident's Substitute Decision Maker (SDM). The progress notes indicated that the SDM had concerns and wanted to be informed immediately if the resident had a fall.

During an interview, RN #132 indicated that staff are to notify the SDM if a resident had a fall and document in the post fall assessment. The ADOC #106 also confirmed that staff are to notify the SDM after a resident has a fall.

According to the progress notes, the resident had a fall and the SDM was not advised

until 2 days later. [s. 6. (5)]

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

Inspector #603 reviewed a complaint submitted to the Director regarding improper care for resident #011.

A review of resident #011's care plan revealed that when staff were administering medications, feeding the resident, and providing personal care, the staff were required to wear protective equipment to maintain safety for all.

During the inspection, Inspector observed a staff member feeding resident #011 in the dining room and was not wearing protective equipment. On a different date, Inspector #603 observed RPN #108 administering medications to resident #011 and was not wearing protective equipment.

An interview with PSW #107 revealed that the staff wear protective equipment at specific times. PSW #107 explained that there was no need to wear protective equipment on another occasion because it was not necessary.

An interview with RPN #108 revealed that the staff did not need to wear protective equipment anymore as the resident had improved. [s. 6. (7)]

6. During an interview with a family member, they indicated that within the last year, there had been medication incidents regarding resident #001.

a) The family member indicated that the staff did not follow the resident's specific protocol and as a result was administered a specific medication.

Inspector #575 reviewed progress notes and noted that on a certain date, the resident was administered a specific medication for day three of the protocol, however later determined the resident was day two.

The resident's plan of care indicated an intervention that the resident was not to receive the specific medication day three and instead the resident was to have a different medication.

During an interview with ADOC #103, they confirmed that the staff member did not follow the resident's plan of care.

b) The complaint also indicated that on a certain date, the resident's morning medications scheduled for 0800hrs were not given on time as prescribed.

The Inspector reviewed a progress note that indicated the resident's medication was administered at 0945hrs.

A review of the resident's plan of care revealed an intervention initiated that indicated the resident's morning medications were to be administered by 0830hrs. [s. 6. (7)]

7. Inspector #575 reviewed a complaint regarding resident #003 that indicated the resident had a fall.

Inspector #575 reviewed the resident's health care record which revealed that on a certain date, the resident had a fall and sustained three injuries. An intervention indicated that the resident required a tilted wheelchair. The tilt should be adjusted up or down once every two hours. The post fall assessment indicated that the resident's wheelchair was not tilted at the time of the fall.

During an interview, ADOC #106 reviewed the documentation and confirmed the wheelchair was not tilted at the time of the fall. [s. 6. (7)]

8. A complaint related to one to one supervision for resident #005 was received.

A review of resident #005's progress notes identified that they required one to one care related to behaviours they were exhibiting. These progress notes indicated that on a certain date, the resident had one to one care up until 1830hrs and once the one to one care staff member assigned completed their assignment for the shift, the resident started wandering in and out of other residents' rooms. On another date, resident #005 was in the TV room along with other residents and they leaned over and almost pulled resident #010's hair. Resident #005 was to have one on one care in place, but the staff member assigned to the one to one was at the nursing station when the incident occurred.

A review of resident #005's plan of care identified that staff should ensure one to one care at all times, and that when one to one staff had breaks, coverage was to be provided.

An interview with ADOC #100 confirmed that the verbal altercation occurred as a result of a scheduling error and that no one to one care was in place at that time. [s. 6. (7)]

9. Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #003. The complaint indicated that the resident was not being assisted with meals.

During the inspection, Inspector #575 observed the lunch dining services on a specific unit. At 1251hrs, the resident was observed with a bowl of soup and was attempting to eat the soup with difficulty, using a spoon. RPN #108 was present at the table assisting another resident. PSW #123 was observed to approach the resident's table, encourage the resident to eat, and then the resident attempted to eat on their own. At 1311hrs, RPN #108 was observed to assist the resident with their soup.

A review of the resident's health care record revealed that the resident needed some physical assistance, full assistance with cutlery, and required soup in specific device to assist them with eating.

During an interview, three staff (RN #118, PSW #124, and PSW #125) all confirmed that the resident required total assistance with eating.

Inspector #575 noted that the soup was in another device and not the one required as indicated in the plan of care and the resident did not receive the assistance required until 20 minutes after their soup was served. [s. 6. (7)]

10. Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI revealed that on a certain date, resident #013 attempted to get up from a chair, lost their balance, and fell. The resident sustained an injury and was sent to the hospital. On their return to the home, they had no other injury and was able to walk with their walker and had no complaints of pain. Days later, the resident started to complain of pain and the area was bruised. The resident was sent for x-rays and received a specific diagnosis and treatment was received.

A review of the current care plan revealed that under mobility, the resident required a wheelchair with a magnetic alarm attached and their foot needed to be elevated due to a medical condition. Under risk for falls, the resident was to wear a protective device.

During the inspection, Inspector #603 observed the resident sitting in a specific chair in the TV room. The resident's foot was not elevated while sitting, they had no wheelchair alarm, and they did not have their protective device.

PSW #113 confirmed that the resident did not have their right foot elevated while sitting in their wheelchair, the wheelchair did not have an alarm on, and the resident had no protective device. [s. 6. (7)]

11. Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 had bothered the resident. Resident #024 sustained an injury.

An interview with PSW #127 revealed that resident #024 often gravitated to resident #025's room which made them agitated.

A review of the resident's care plan revealed that the resident was to have a yellow strip at the door to prevent wanderers from going in and out of their room.

During the inspection, Inspector observed that the resident did not have a yellow strip in their doorway while they were laying in their bed. ADOC #103 explained that the yellow bands were often removed by wandering residents. [s. 6. (7)]

12. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #575 reviewed an anonymous complaint regarding the care of resident #004. The complaint indicated that the resident's condition deteriorated over a period of three days and there was a lack of assessment by the staff.

The Inspector reviewed the resident's plan of care. The Inspector noted a specific physician's order that indicated for staff to perform an intervention and chart in Point Click Care (PCC) and four days later, another physician's order indicated for staff to perform the intervention every day for seven days.

The Inspector interviewed ADOC #103 regarding where the intervention would be documented. ADOC #103 indicated that it would be documented in the progress notes if it was a physician's order and that it would be started the next day after the order was written. The ADOC also indicated that it could be recorded on the electronic medication

administration record (eMAR).

The Inspector reviewed the progress notes for the same time frame as the physician orders and noted that the resident's intervention was not recorded in the progress notes until a certain time and it should have been recorded before that date. The eMAR was signed that it was completed on all days; however, there was no documentation of the interventions until a later date. [s. 6. (9) 1.]

13. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #575 reviewed a complaint regarding continence care for resident #001.

On a certain date, the Inspector reviewed the resident's care plan and kardex. Under the focus urinary incontinence, an intervention indicated that the resident wore a brief. The continence care assessment indicated that the resident used a pad.

On a certain date, the Inspector observed PSW #104 apply an incontinent product to the resident.

During an interview, PSW #104 indicated that they reviewed the resident's kardex and care plan on Point Click Care (PCC) for directions on the type of care to provide a resident. PSW #104 indicated that resident #001 wore a medium brief and that they used to wear a large brief.

During an interview, ADOC #103 confirmed that the resident no longer wore the large brief and that the plan of care was not updated to reflect the current product used by the resident. [s. 6. (10) (b)]

14. Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI revealed that on a certain date, resident #013 attempted to get up from a chair, lost their balance and fell. The resident sustained an injury and was sent to the hospital. On their return to the home, they had no other injury and was able to walk with their walker, and had no complaints of pain. Days later, the resident complained of pain and the area was bruised. The resident was sent for x-rays and received a diagnosis and treatment was provided.

A review of the current care plan revealed that the resident could weight bear and was able to transfer from the bed independently. The staff were to provide weight bearing support for all transfers. Under mobility, the resident required a wheelchair with a magnetic alarm attached, a pillow was needed and the foot needed to be elevated. Under risk for falls, the resident was to wear a protective device.

During the inspection, Inspector #603 observed the resident sitting in a specific chair in the TV room. The resident had no cast, their foot was not elevated while sitting, they had no wheelchair alarm, and they had no protective device.

An interview with PSW #113 revealed that the resident was not able to weight bear and was a "full lift". A Hoyer Lift and 2 person assist was needed for all care and transfer. PSW #113 confirmed that the resident no longer required a cast on their left wrist, their right foot did not need to be elevated while sitting, and the resident had no hip protectors on. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”. 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 ensuring that the plans of care set out clear directions to staff and others who provide direct care to resident #010 and #011 and ensuring that resident #003's SDM is provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings, and equipment were kept clean and sanitary.

Inspector #603 reviewed a complaint submitted to the Director, alleging an unclean home. Resident #011's family member claimed that the home was very dirty, carpets were stained, and upholstery and floors were unclean.

An interview with resident #011's family member who was visiting, confirmed that the resident's room, especially the floors were often not cleaned. Dirt is often left on the floor for days.

On two specific days during the inspection, Inspector observed resident #011's room to be cluttered, dusty, and the floor and floor equipment had dirt (sand, food, drippings, and shredded tissue paper) accumulated on them. The same dirt was on the floor and floor equipment for both days.

A review of the home's Cleaning Frequencies-Housekeeping Policy #XII-D-10.50 revealed that the housekeeping staff will follow each cleaning frequency schedule as indicated and the daily schedule included: night stand and dresser surfaces and floors, including the washroom floors. There was no mention of cleaning or who should be responsible in cleaning the resident's floor mats.

An interview with Housekeeping Staff #102 revealed that they try and clean the resident's room every day. This includes cleaning the floors and the washrooms. The floor equipment are to be cleaned by nursing staff but they don't have time, so the housekeeping staff will try and do it for the nursing staff, when they have time.

An interview with the Director of Environmental Services revealed that the resident's rooms are not cleaned every day, they are simply "spot cleaned as needed". A deep cleaning is done once a month and that includes dusting the rooms. The floor equipment are to be cleaned by the nursing staff.

An interview with ADOC #103 revealed that it was the home's expectation that the resident's rooms are cleaned every day. This includes floors, washrooms, dusting, and equipment. Once a month, a deep cleaning is done and that includes bed mattresses and furniture are moved for a thorough cleaning. [s. 15. (2)]

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 ensuring that the home, furnishings, and equipment such as floor mats in the case of resident #011, are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under the Act, cannot come to work.

During the inspection, Inspector interviewed the Director of Care (DOC), who explained that the home did not have a written back-up plan for nursing and personal care staffing that addressed situations when staff cannot come to work. The DOC explained that the home had at least one ADOC on days, one on evenings, and a weekend manager to deal with staffing issues. [s. 31. (3) (d)]

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 ensuring that the staffing plan includes a written back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under the Act, cannot come to work, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

On a certain date, Inspector #603 observed the breakfast meal services on a specific unit. The staff served all residents, cream of wheat and then toast. The staff did not offer choices of the planned menu items to the residents.

The posted daily breakfast menu indicated:
Apple juice
Stewed Prunes
Cream of Wheat
Assorted Cold Cereal Vanilla Yogurt
Peanut Butter
Whole Wheat Toast
White Toast
Margarine
Assorted Jam
2% milk
Coffee
Water
Tea

An interview with FSA #109 confirmed that all residents received cream of wheat and then toast with a choice of jam. There were no stewed prunes available and FSA #109 confirmed that prune juice had been substituted for the stewed prunes.

An interview with PSW #110 who was serving the food confirmed that every morning, there is no time to go around and ask residents for their choice and since the staff know the residents so well, they don't offer them choices. [s. 71. (4)]

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 ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A complaint was submitted to the Director by resident #008's family member, who received a voicemail message, and could hear RN #118 and PSW #119 mocking and imitating resident #008. The resident requested to make a call to another family member and the staff informed them that if they wanted to make numerous calls, they would have to get their own phone.

Inspector #543 reviewed documentation of the home's internal investigation related to the incident where staff spoke inappropriately to resident #008 (overheard in a voicemail mocking and imitating the resident), which identified that RN #118 and PSW #119 were in violation of the Resident's Bill of Rights. [s. 3. (1) 1.]

2. During the inspection, Inspector #603 entered a specific unit and was observing a resident wheeling themself in the hallway and all of sudden, RPN #131 yelled out from the back of the dining room and asked "Excuse me, who are you?" referring to the Inspector, while feeding a resident. Inspector observed three staff members having a loud conversation amongst themselves while feeding residents. The conversation went on for approximately 5-7 minutes.

A review of the home's current Pleasurable Dining Policy revealed that all residents will have a pleasurable dining experience that promotes individual nutritional care needs and the Registered Staff will oversee and monitor all aspects of pleasurable dining, including but not limited to: promotion of a relaxed and quiet dining atmosphere.

An interview with RPN #131 revealed that the home's expectation is that no staff should be having a loud conversation over residents in the dining room and should be having conversations with residents and engaging them in the conversations. [s. 3. (1) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #010. The complainant indicated that they submitted a written complaint to the home on a specific date.

During an interview, the Administrator confirmed a written complaint was received via email on that same date. The Administrator indicated that they mailed the complaint to the Director, four days later and a follow-up letter, a few weeks later, however they were returned (wrong mailing address). The Administrator indicated that the complaint was then emailed one month later.

The Inspector confirmed with the Director that they did not receive the written complaint from the home. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident’s assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Inspector #575 observed the lunch dining service on a specific unit.

Inspector #575 observed PSW #133 serve main entrees to three residents before they were completed their soup and two residents were served dessert before completing their entrees.

During an interview, PSW #133 indicated that staff are aware that they are to serve course by course, however, it was difficult on this home area. PSW #133 indicated that they have one hour to serve all food and they had to serve the food to the residents before the hour was completed. [s. 73. (1) 8.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

Inspector #575 observed lunch dining services on a specific unit. PSW #123 was observed to approach resident #003 and encourage them to eat. PSW #123 then stood beside the resident and assisted the resident with eating their soup.

During an interview, PSW #123 stated that the expectation was that staff sit while assisting residents with eating. [s. 73. (1) 10.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include in their investigation report, the outcome or current status of the individual or individuals who were involved in the incident.

A complaint was submitted to the Director which related to RN #118 and PSW #119 speaking inappropriately to resident #008.

RN #118 and PSW #119 were overheard on the resident's family member's voicemail, mocking and imitating the resident's voice. The staff also refused to allow the resident to make a second phone call, stating "No, you need to get your own phone if you want to make multiple calls".

Once the home was notified of the incident, a Critical Incident Report (CI) was initiated. A review of the CI revealed that it was not updated to include the outcome of the investigation.

An interview with the Director of Care, confirmed that the CI intake was not updated to include the outcome of the investigation. [s. 104. (1) 3. v.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Inspector #575 reviewed an anonymous complaint regarding the care of resident #004. The complaint indicated that upon visiting the resident on a certain date, it was apparent that the resident had suffered a serious medical issue since the previous visit, 2 days earlier, which turned out to be a serious diagnosis. According to the complainant, 2 days before the serious medical issue, the resident was ambulatory and chatty and two days later, the resident was in a wheelchair, unable to speak and unable to swallow.

The Inspector reviewed the resident's progress notes from those two specific days. The day before the serious medical issue, the progres notes indicated that the resident was ambulating with their walker, however was noted to be weak during walking, was hard to understand, and was drooling from their right side of their mouth. At a later time during that day, the resident was lethargic and difficult to understand their speech. The next day, the resident had an unsteady gait, their speech was unclear and they were dragging their right leg when attempting to walk. Later that afternoon, the resident's Substitute Decision Maker (SDM) arrived to the home for a visit and was advised of the resident's condition regarding two possible different diagnoses.

The resident's SDM was not advised of the resident's change in condition until they arrived at the facility on the second day.

During an interview, ADOC #103 indicated that staff should have notified the SDM the day before, to advise of the resident's condition. The DOC confirmed that staff are to notify the resident's SDM when there is a change in condition. [s. 107. (5)]

Issued on this 19th day of May, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE LAVICTOIRE (603), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_391603_0005
Log No. / Registre no:	005301-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 18, 2016
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
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUANNE CAMPEAU

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to residents a specified in the plan. The plan will include the following:

1. A process to ensure that the care set out in the plan of care for each resident is provided to the resident as specified in the plan.
2. An auditing process that will identify when staff are not providing care as specified in the plans, so that corrective action can be taken.
3. A multidisciplinary process to ensure clear communication between front line staff, so that the care is provided to the residents as specified in the plans.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by June 1, 2016, with full compliance by June 15, 2016.

Grounds / Motifs :

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

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 had bothered the resident. Resident #024 sustained an injury.

An interview with PSW #127 revealed that resident #024 often gravitated to resident #025's room which made them agitated.

A review of the resident's care plan revealed that the resident was to have a yellow strip at the door to prevent wanderers from going in and out of their room.

During the inspection, Inspector observed that the resident did not have a yellow strip in their doorway while they were laying in their bed. ADOC #103 explained that the yellow bands were often removed by wandering residents.

(603)

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

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI revealed that on a certain date, resident #013 attempted to get up from a chair, lost their balance, and fell. The resident sustained an injury and was sent to the hospital. On their return to the home, they had no other injury and was able to walk with their walker and had no complaints of pain. Days later, the resident started to complain of pain and the area was bruised. The resident was sent for x-rays and received a specific diagnosis and treatment was received.

A review of the current care plan revealed that under mobility, the resident required a wheelchair with a magnetic alarm attached and their foot needed to be elevated due to a medical condition. Under risk for falls, the resident was to wear a protective device.

During the inspection, Inspector #603 observed the resident sitting in a specific chair in the TV room. The resident's foot was not elevated while sitting, they had no wheelchair alarm, and they did not have their protective device.

PSW #113 confirmed that the resident did not have their right foot elevated while sitting in their wheelchair, the wheelchair did not have an alarm on, and the resident had no protective device. (603)

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

A complaint related to one to one supervision for resident #005 was received.

A review of resident #005's progress notes identified that they required one to one care related to behaviours they were exhibiting. These progress notes indicated that on a certain date, the resident had one to one care up until 1830hrs and once the one to one care staff member assigned completed their assignment for the shift, the resident started wandering in and out of other residents' rooms. On another date, resident #005 was in the TV room along with other residents and they leaned over and almost pulled resident #010's hair. Resident #005 was to have one on one care in place, but the staff member assigned to the one to one was at the nursing station when the incident occurred.

A review of resident #005's plan of care identified that staff should ensure one to one care at all times, and that when one to one staff had breaks, coverage was to be provided.

An interview with ADOC #100 confirmed that the verbal altercation occurred as a result of a scheduling error and that no one to one care was in place at that time. (543)

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

Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #003. The complaint indicated that the resident was not being assisted with meals.

During the inspection, Inspector #575 observed the lunch dining services on a specific unit. At 1251hrs, the resident was observed with a bowl of soup and was attempting to eat the soup with difficulty, using a spoon. RPN #108 was present at the table assisting another resident. PSW #123 was observed to approach the resident's table, encourage the resident to eat, and then the resident attempted to eat on their own. At 1311hrs, RPN #108 was observed to assist the resident with their soup.

A review of the resident's health care record revealed that the resident needed some physical assistance, full assistance with cutlery, and required soup in specific device to assist them with eating.

During an interview, three staff (RN #118, PSW #124, and PSW #125) all confirmed that the resident required total assistance with eating.

Inspector #575 noted that the soup was in another device and not the one required as indicated in the plan of care and the resident did not receive the assistance required until 20 minutes after their soup was served. (575)

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

Inspector #575 reviewed a complaint regarding resident #003 that indicated the resident had a fall.

Inspector #575 reviewed the resident's health care record which revealed that on a certain date, the resident had a fall and sustained three injuries. An intervention indicated that the resident required a tilted wheelchair. The tilt should be adjusted up or down once every two hours. The post fall assessment indicated that the resident's wheelchair was not tilted at the time of the fall.

During an interview, ADOC #106 reviewed the documentation and confirmed the wheelchair was not tilted at the time of the fall. (575)

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

During an interview with a family member, they indicated that within the last year, there had been medication incidents regarding resident #001.

a) The family member indicated that the staff did not follow the resident's specific protocol and as a result was administered a specific medication.

Inspector #575 reviewed progress notes and noted that on a certain date, the resident was administered a specific medication for day three of the protocol, however later determined the resident was day two.

The resident's plan of care indicated an intervention that the resident was not to receive the specific medication day three and instead the resident was to have a different medication.

During an interview with ADOC #103, they confirmed that the staff member did not follow the resident's plan of care.

b) The complaint also indicated that on a certain date, the resident's morning medications scheduled for 0800hrs were not given on time as prescribed.

The Inspector reviewed a progress note that indicated the resident's medication was administered at 0945hrs.

A review of the resident's plan of care revealed an intervention initiated that indicated the resident's morning medications were to be administered by 0830hrs. (575)

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

Inspector #603 reviewed a complaint submitted to the Director regarding improper care for resident #011.

A review of resident #011's care plan revealed that when staff were administering medications, feeding the resident, and providing personal care, the staff were required to wear protective equipment to maintain safety for all.

During the inspection, Inspector observed a staff member feeding resident #011 in the dining room and was not wearing protective equipment. On a different date, Inspector #603 observed RPN #108 administering medications to resident #011 and was not wearing protective equipment.

An interview with PSW #107 revealed that the staff wear protective equipment at specific times. PSW #107 explained that there was no need to wear protective equipment on another occasion because it was not necessary.

An interview with RPN #108 revealed that the staff did not need to wear protective equipment anymore as the resident had improved.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as WN during Inspection #2015_356618_0018, a WN and VPC during Inspection #2014_168202_0011.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated actual harm/risk and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of May, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sylvie Lavictoire

Service Area Office / Bureau régional de services : Toronto Service Area Office