Ontario

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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_605213_0023	015665-17, 021469-17, 022989-17, 027913-17, 028343-17, 028946-17, 000193-18, 000426-18, 008796-18, 009842-18, 019955-18, 023281-18, 023719-18, 023850-18, 025507-18, 032240-18, 032315-18, 004552-19, 004761-19, 009718-19	Critical Incident System

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 Care Community
2656 6th Line Bradford ON L3Z 2A1

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

RHONDA KUKOLY (213), JULIE DALESSANDRO (739), MEAGAN MCGREGOR (721), SAMANTHA PERRY (740)

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): June 8, 9, 10, 11, 12, 2019

The following Critical Incident System intake(s) related to the same issue were completed during this inspection:
Log #032240-18, Critical Incident #2905-000051-18 related to falls
Log #009718-19, Critical Incident #2905-000022-19 related to falls
Log #004761-19, Critical Incident #2905-000006-19 related to falls
Log #019955-18, Critical Incident #2905-000001-18 related to a fracture of unknown origin
Log #004552-19, Critical Incident #2905-000005-19 related to a fracture of unknown origin
Log #027913-17, Critical Incident #2905-000052-17 related to a missing controlled substance
Log #028343-17, Critical Incident #2905-000056-17 related to a missing controlled substance
Log #032315-18, Critical Incident #2905-000054-18 related to responsive behaviours

Log #021469-17, Critical Incident #2905-000041-17 related to responsive behaviours

Log #023850-18, Critical Incident #2905-000032-18 related to responsive behaviours

The following Critical Incident System intakes were reviewed during this critical incident inspection:
Log #015665-17, Critical Incident #2905-000036-17 related to responsive behaviours

Log #022989-17, Critical Incident #2905-000044-17 related to responsive behaviours

Log #028946-17, Critical Incident #2905-000056-17 related to falls
Log #000193-18, Critical Incident #2905-000001-18 related to falls
Log #000426-18, Critical Incident #2905-000002-18 related to falls
Log #008796-18, Critical Incident #2905-000017-18 related to falls
Log #009842-18, Critical Incident #2905-000019-18 related to falls

Log #023281-18, Critical Incident #2905-000031-18 related to falls
Log #023719-18, Critical Incident #2905-000030-18 related to responsive behaviours

Log #025507-18, Critical Incident #2905-000039-18 related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Associate Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Recreation Assistant and the Pharmacy Manager.

The Inspectors also made observations and reviewed health records, internal investigation records, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
2 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	Légende 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to a resident’s fall by resident on an identified date, which resulted in them sustaining an injury that resulted in a transfer to hospital and a significant change in condition. The CIS report stated that the resident had several identified falls prevention interventions in place.

A review of resident’s progress notes in Point Click Care (PCC) showed the following:
- An assessment note from six days prior to the reported fall, stating that due to an injury and declining mobility, the resident was in a reclining wheelchair and all falls preventative measures were applied.
- An assessment note from the date of the reported fall, stating that the resident fell from their reclining wheelchair and after the fall, was put in a reclined position in their their wheelchair with falls prevention interventions applied.
- A progress note from seven days following the fall, stating that the resident had several identified fall prevention interventions in place.

Inspector #721 observed resident and their falls prevention interventions in place on the following dates and times during the inspection:
- On an identified date one at a specified time, they were not present in their room and there were specific falls prevention interventions in place.
- On a different date at a specified time, they were not present in their room and there were specific falls prevention interventions in place.
- On that same date a different time, they were sitting in the nursing station with specific falls prevention interventions in place.
- On that same date at a different time, they were sitting in the nursing station with specific falls prevention interventions in place.
- On a different date at a specified time, they were sleeping in their bed and there were specific falls prevention interventions in place.

A review of the homes policy titled "Falls Prevention & Management", Policy #VII-G-30.10, last revised April 2019, stated in part the following:
- Upon completion of the detailed fall risk assessment, the nursing staff will update the

plan of care with associated risk level and interventions.
- The Personal Support Worker (PSW) staff will utilize fall prevention interventions identified on the resident's plan of care and the "Fall Risk Factors & Related Interventions" sheet.
- Each member of the Interprofessional Team will complete their respective assessments and discuss the appropriate interventions with the interprofessional care team and document all interventions added to the plan of care.
- A falls prevention kit should be accessible to frontline team members at all times. The kit is an accumulation of various items that can help prevent a resident fall. Items in the kit may include non-slip socks, chair and bed alarms, night light, hip protectors, reachers, crash mats, helmet etc. Team members are to inform the Nurse if an item is introduced to a resident. Nursing staff is to update the resident's plan of care to include the new intervention.

During an interview, when asked how they would know if a resident was at risk for falls, a Personal Support Worker (PSW) stated that they would look at the resident's Kardex. The PSW told the Inspector that if specific interventions were in place for a resident to help minimize their risk for falls this would be written in their Kardex or Care Plan in PCC.

During an interview, when asked how they would know if a resident was at risk for falls, a Registered Practical Nurse (RPN) stated they would usually write on the residents Care Plan in PCC what their risk was. When asked how PSW staff knew what specific interventions were in place for a resident to help minimize their risk for falls, they stated it was on the Care Plan. The RPN told the Inspector that the resident was at high risk of falling and specified falls prevention interventions were in place to reduce their risk of falling.

A review of the resident's Care Plan in PCC did not show any documentation regarding them being at high risk for falls or having the observed falls prevention interventions.

During an interview, the Director of Care (DOC) reviewed resident's clinical record with the Inspector. When asked how staff would know if a resident was at risk of falling and what interventions were in place to reduce their risk of falling, the DOC stated that this would be indicated on a resident's Care Plan and Kardex in PCC. The DOC told the Inspector that the resident was at risk of falling and had several specific falls prevention interventions in use. When asked where it was documented in the resident's plan of care that they had the specified falls prevention interventions, the DOC reviewed resident's

Care Plan in PCC and stated they were not there. The DOC said that staff knew the resident required these interventions because they would refer to the homes “Falls Prevention & Management” policy for any resident that was at high risk of falling and that every resident who was at risk of falling would have these interventions in place. When asked where it was documented in the resident’s plan of care that they were at high risk of falling, the DOC stated it was documented in their progress notes and that PSW staff didn’t have access to these progress notes. When asked how PSW staff knew what interventions were in place if they did not have access to progress notes, the DOC said that registered staff determined what interventions would be in place and would communicate this to PSW staff at post-fall huddles.

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions for falls prevention interventions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The home reported two critical incidents to the Ministry of Health and Long Term Care, related to missing controlled substances on two identified dates.

The Inspector observed a controlled substance count on one home unit on an identified date. During this count with two registered nursing staff, they checked controlled substances housed in the fridge in the medication room. The medication room was found to be locked, the fridge was not locked, they removed a small metal box from the fridge that was locked and contained an injectable controlled substance to count.

Two days later, the Inspector observed a controlled substance count on a different home unit. During this count with two registered nursing staff, they checked controlled substances housed in the fridge in the medication room. The medication room was found to be locked, the fridge was not locked, they removed a small metal box from the fridge that was locked and contained an injectable controlled substance to count.

In an interview with the Director of Care (DOC) and the Administrator, they agreed that the controlled injectable medication, found in the fridge in the medication room was not in a double-locked stationary cupboard in the locked area. [s. 129. (1) (b)]

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. s. 114 (2), the licensee was required to have a written policy developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with Medical Pharmacies’ “Individual Monitored Medication Record” policy (revised January 2018) when a registered nursing staff member didn’t document the administration of a controlled substance on the Individual

Monitored Medication Record. The staff also did not comply with Medical Pharmacies’ “Shift Change Monitored Drug Count” (revised November 2018) when the Individual Monitored Medication Record was not checked with the medication card amount during the controlled substance shift count.

Medical Pharmacies’ policy #6-5 “Individual Monitored Medication Record”, last revised January 2018 stated: Sign on the ‘Individual Monitored Medication Record’ each time a dose is administered. Include the date, time, amount given, amount wasted, and new quantity remaining.

Medical Pharmacies’ policy #6-6 “Shift Change Monitored Drug Count”, last revised November 2018 stated: Two staff (leaving and arriving), together:
a. count the actual quantity of medications remaining.
b. record the date, time, quantity of medication and sign in the appropriate spaces on the ‘Shift Change Monitored Medication Count’ form.
c. confirm actual quantity is the same as the amount recorded on the ‘Individual Monitored Medication Record’ for prn, liquid, patches or injectable.

The home reported two critical incidents to the Ministry of Health and Long Term Care, related to missing controlled substances on two identified dates.

The Inspector observed a controlled substance count on an identified date and time on one home unit. During this count with two Registered Practical Nurses (RPN), they checked the amount remaining in the medication card containing an identified controlled substance for an identified resident with the Individual Monitored Medication Record. There were 19 tablets remaining in the card and the Individual Monitored Medication Record indicated there were 20 tablets remaining. The RPNs stated that someone must have forgotten to sign the Individual Monitored Medication Record, they would check and report the incident to the charge nurse.

A review of the resident’s electronic Medication Administration Record (eMAR), for two months, was completed. One eMAR showed that the resident was administered a controlled substance on an identified date and time. In reviewing the Individual Monitored Medication Record, it was noted that the above administration was not documented.

In an interview with the Director of Care (DOC), they said that the home uses the Medical Pharmacies’ policies for all of their medication policies. The DOC said that an RPN administered a controlled substance on an identified date and signed the eMAR but did

not sign the Individual Monitored Medication Record. The DOC also said that all of the staff completing the shift change monitored drug count from that date to the date of the observed count, a two week period, did not confirm actual quantity was the same as the amount recorded on the Individual Monitored Medication Record. The DOC said that the staff did not follow the process identified in the policies.

Staff did not comply with the Individual Monitored Medication Record policy when they did not document an administration on the form and did not comply with the Individual Monitored Medication Record policy when staff didn't confirm actual quantity was the same as the amount recorded on the Individual Monitored Medication Record for a two week time period. [s. 8. (1) (b)]

WN #4: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition within one business day.

The home submitted a Critical Incident System (CIS) to the Ministry of Health and Long-Term Care (MOHLTC), related to a fall, which resulted in a resident sustaining an injury that resulted in a transfer to hospital and a significant change in condition. The CIS report stated that the resident had previously fallen approximately two weeks prior, were transferred to hospital and suffered an injury that resulted in a significant change in condition.

A review of the resident's Minimum Data Set (MDS) Annual Assessment, in Point Click Care (PCC), completed prior to the previous falls, showed they required limited assistance for transferring and walking.

A review of the resident's progress notes in PCC showed the following related to the fall previous to the one reported in a CIS:
- An assessment note from an identified date, stating the resident was found by staff on the floor in their room and were unable to stand up on their own as per usual.
- An assessment note from the following date, stating that they were being referred for a physiotherapy assessment as they fell and were unable to stand on their own as per usual. A Registered Practical Nurse (RPN) assessed them after the fall and no injuries were noted.
- A progress note from later that date stating, that they were exhibiting unusual behaviours and an assistive device was implemented.
- A progress note from the following date stating that they were sent to hospital for further assessment of a suspected significant injury identified on assessment by physiotherapist.

- A physiotherapy note from later that date, stating that specified pain was noted on assessment.
- A progress note from later that date, stating that the home was informed by the resident's power of attorney that that they had sustained a significant injury and would require assistive devices and all falls prevention measures in place upon return to the home.
- A progress note from the following date, stating that they returned to the home with a confirmed significant injury.
- A progress note from later that date, stating that they were to remain in bed until assessed by physiotherapist.
- Three further progress notes over the next two dates stating that they remained in bed the previous shift.
- A physiotherapy note the following date, stating that they required specified assistive devices and were awaiting orders from the physician.
- A progress note from later that date, stating that they were transferred by staff and used assistive devices
- An assessment note from days later, stating that they were using assistive devices due to a significant change.

A review of the resident's Care Plan in PCC with showed the resident was independent

for mobility and transfers prior to the first fall and then required extensive assistance following the second fall.

During an interview, when asked what the resident's ambulation and transfer status was before the first fall and sustained an injury, a Personal Support Worker (PSW) stated that they were walking around. The PSW stated that after this fall they were unable to walk and required extensive assistance and assistive devices.

A review of the MOHLTC Critical Incident reporting system showed that no CIS reports were submitted related to the documented fall by the resident which resulted in a transfer to hospital on the identified date of the first fall and subsequent change in their ambulation and transfer status upon their return from hospital the following day.

During an interview, the Director of Care (DOC) reviewed the resident's clinical record with the Inspector. When asked about the resident's history of falls, DOC stated that they had a history of falls which included a fall that resulted in an injury that resulted in a significant change in condition. The DOC told the Inspector that prior to the fall that resulted in an injury and a significant change in status, the resident did not require assistive devices or staff assistance and after the fall, they did. When asked if they considered the injury the resident sustained from that fall to have resulted in a significant change in their condition, the DOC stated they would. When asked if a CIS report was submitted to the MOHLTC related to that fall, which resulted in a significant change in their condition, the DOC stated they didn't think so and that they would expect one should have been submitted.

The licensee failed to ensure that the Director was informed within one business day, when a resident fell and had sustained an injury which resulted in a significant change in their condition. [s. 107. (3) 4.]

Issued on this 16th day of July, 2019

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

Original report signed by the inspector.