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

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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
Aug 16, 2019	2019_595110_0003	007182-18, 009362-18, 021051-18, 031669-18	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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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

DIANE BROWN (110)

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): July 9, 10, 11, 12, 15, 16, 17, 19, 23, 24, 2019.

During this inspection the following complaints were inspected:
Log #021051-18 related to an unknown cause of resident change in status.
Log #007182-18 related to inappropriate responsive behaviors and alleged abuse
Log #009362-18 related to lack of resident feeding assistance; food production area unclean and unsafe; poor quality texture modified foods, lack of snack to service to all residents,
Log #031669-18 related to insufficient staffing and residents not receiving proper mealtime assistance with meals.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Dietary Services, Registered Dietitian, Assistant Director of Care(s), registered nursing staff, BSO resource team, personal support workers, cooks, dietary aides.

During this inspection the inspector observed meal service, snack service and food production areas. The inspection included a review of resident health records, home policies, food handling scheduled and hours along with cleaning and nourishment audits.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Responsive Behaviours
Snack Observation

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
6 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

The Ministry of Long Term Care received a complaint, log #019955-18, which indicated resident #003 was transferred to the hospital on an identified date and diagnosed with an unexpected change in health status. The complainant was concerned around the circumstances of resident #003's transfer to hospital and subsequent diagnosis of unknown origin.

A record review of resident #003's health record identified resident #003's current diagnosis, level of care for ADL's and the identified transfer to hospital and subsequent unexpected change in status as expressed by the complainant.

A record review identified a progress note the morning of an identified date just prior to the resident's transfer to hospital which identified a change in the resident and a note documenting resident return from the hospital and their change in health status.

A record review of the resident's written plan of care in place at the time of the resident's change in status identified their level of assistance for bathing, bathing time and bathing days.

An interview with full time PSW #123 confirmed they had bathed resident #003 on the day prior to the resident's change in health status. The staff shared the individualized process for bathing resident #003 and also shared the process should be written in the

resident's plan of care for others who replace them and was not.

An interview with full time PSW #121 on days shared that the process for bathing resident #003, which was contrary to how PSW #123 had explained bathing the resident. The PSW further stated they are not supposed to do it that way from a dignity perspective and that the process and type of mechanical lifts to be used should be identified in the resident's written care plan.

An interview with full time day shift PSW #124 shared another approach for bathing resident #003.

An interview with RPN #122, who documented the resident was bathed on the same identified date, shared the process for bathing resident #003. The process shared was not consistent with how full time PSW #123 had bathed the resident. The RPN shared they were unaware of how staff bath resident #003 and that directions on bathing the resident, including the use of individualized equipment should be written in the plan of care and was not.

An interview with RPN #125 shared how staff were expected to bath resident #003, which was not consistent with how full time PSW #123 had reported bathing the resident.

The RPN shared they were not exactly sure how staff completed the bathing task, and further stated they did not know how staff could bath the resident the way PSW #123 had expressed. The resident's written plan of care for bathing was created by RPN #125.

An interview with ADOC #126 stated the process for bathing resident #003, and shared it would be difficult to complete the bathing task the way PSW #123 had explained bathing the resident. The ADOC identified they needed to state the process in the resident's written plan of care.

The licensee failed to set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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.

The Ministry of Long Term Care received a complaint, log #019955-18, related to resident #003.

A record review identified a progress note the morning of an identified date just prior to the resident's transfer to hospital which identified a change in the resident and a note documenting resident return from the hospital and their change in health status.

A record review of the resident's written plan of care in place at the time of the incident identified resident #003's level of assistance for repositioning in bed and that the resident is unable to assist.

During separate interviews with RPN #110, PSW #132 and PSW #128 they all shared that resident #003 was difficult to reposition, not easily turned and you always need the identified number of staff to reposition and change them.

An interview with full time afternoon RPN #122 who worked the day prior to the resident's hospitalization identified that they had administered medication to resident #003 at around 2000hrs that evening and did not notice the resident to be in distress. The RPN shared that during their shift they did, multiple times, reposition resident #003. The RPN also shared how they repositioned the resident and acknowledged that the resident's written plan of care had not been followed.

An interview with ADOC #126 confirmed that staffing level required to reposition resident #003 when they are in bed and that RPN #122 had not followed the resident's written plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set 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 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 its furnishings and equipment maintained in a safe condition and in a good state of repair.

This inspection protocol (IP) was initiated by a complaint, log #009362-18, related to the lack of cleanliness in the kitchen.

A unannounced tour of the kitchen food production area was conducted on July 15, 2019 at 1430hrs. Observations were made with cook #108. The food production area overall was unclean in appearance as evidenced by the following:
-Ingredients bins were soiled on the outside with the appearance of dried food and drippings on both the lids and containers.
-Flat bed cart wheels were soiled with a build up of dried food.
-Foot operated garbage pail was heavily soiled with food and liquid spills both lid and base.
-Convection ovens thermometer dials were heavily soiled with dried food and dried liquid drips on the doors.
-Warming unit appeared soiled with drips of dried food inside and out on the door.
-Steamer doors and handle was soiled with food and drip markings.

An interview with dietary aide #109 shared that the cleanliness of the kitchen could be better and that it was related to time restraints on staff to complete the deep cleaning and that there was no regular scheduled deep cleaner.

The Food Service Director (FSD) was asked to observe the unclean food production area with the Inspector. The FSD confirmed the kitchen was not clean to an acceptable standard. The Food Service Director a day later shared with Inspector that a regular scheduled deep cleaning shift had now been added to the dietary departments schedule. The inspector conducted a follow-up observation of the kitchen which revealed cleaner food service equipment. [s. 15. (2) (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 its furnishings and equipment maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering; any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

This IP was initiated related to a complaint, log #007182-18, whereby resident #001's substitute decision maker (SDM) was concerned about responsive behaviors between resident #001 and co- resident #002. The complainant felt their concerns for resident #001's safety were not taken seriously.

A record review of the resident's electronic health record identified resident #001 with a diagnosis of an identified disease, and a cognitive performance scale (CPS) score of 3, which is defined as moderate cognitive impairment.

A record review of progress notes, over a four month period until resident #001 passed away, identified 15 entries whereby resident #001 was known to demonstrate a responsive behavior towards co-resident #002. On two occasions documentation

revealed resident #001's SDM was upset with resident #001's behaviors towards co-resident #002.

A record review of resident #001's written plan of care failed to identify resident #001's responsive behaviours towards co-resident #002.

A record review of resident #002's written plan of care identified a problematic manner in which the resident acts, characterized by inappropriate behaviour towards identified co-residents.

An interview with PSW #100 shared that they were familiar with resident #002's inappropriate behaviors. The PSW shared they were advised to keep an eye out for co-residents, like resident #001, who demonstrated a responsive behavior but shared nothing specific was in place.

An interview with PSW #101 revealed that resident #001 demonstrated responsive behaviors towards resident #002. The PSW stated they redirected resident #001 and used a specialized aide but that the interventions were only sometimes effective.

An interview with PSW #107 shared that resident #001 demonstrated responsive behaviors towards co-resident #002 all the time and that it had been reported that resident #002 had inappropriate behaviors towards resident #001 and that resident #001's SDM did not want that to happen. The staff stated the interventions were not effective.

An interview with PSW #117 shared that resident #001 changed and demonstrated responsive behaviors towards co-resident #002. The PSW stated that interventions were hit and miss.

An interview with RPN #119 revealed that resident #001 was becoming "lured" by resident #002 and that resident #002 would lure identify residents into their room. The RPN shared that they knew of resident #002's history of inappropriate behaviors from their plan of care. The RPN shared that a referral to BSO should have been initiated based on resident #001's responsive behaviors directed towards resident #002, especially given resident #002's known behaviors.

An interview with BSO resource team member #103 stated that they had not received a referral for resident #001 which triggers a formal assessment and care plan for resident

#001. The BSO resource team member #103 stated that given resident #001's new behavior and resident #002 safety risk of inappropriate behaviors a referral should have been sent at the onset of resident #001's behavior.

A review of the home policy entitled "Responsive Behaviors Management" dated April 2019 stated the nurse will complete an electronic Responsive Behavior Referral to the Internal Behavioral Support Lead/Designate when there is a new, worsening or change in responsive behaviors and document in the individualized plan of care any measures to identify level of risk (low, medium) or crisis triggers; promote a safe environment; identify pain and discomfort; monitor, evaluate and document new or changed antipsychotics/analgesics, antidepressants, mood stabilizers e.g. bipolar; report changes in shift report and alert protocols used such as Purple Dot Protocols or another flag system used that is known to the team members.

The ADOC confirmed awareness of the SDM's concern involving resident #001 and co-resident #002. The ADOC identified that a responsive behaviour plan of care based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering; any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day had not been developed and that once resident #001 started demonstrating the new behavior a referral should have been initiated to BSO. The ADOC further shared that nursing staff should have initiated a written plan of care at the onset of resident #001's new behaviors. [s. 26. (3) 5.]

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 responsive behaviour plan of care based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering; any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, 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. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).**

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

This IP was initiated related to a complaint, log #009362-18 which identified that PSW staff do not offer a drink or snack at snack service to residents in their rooms and only serve those residents located in the TV room on first floor.

The home's policy entitled Snack Service Policy #VII-I-10.70, dated January 2015, states that all residents shall receive snacks in accordance with the legislative guidelines and the residents' personal diet information.

An unannounced observation of the morning snack service was conducted during the inspection on an identified home area. At 1023 hrs the Inspector identified 12 residents in the home area lounge and two PSWs, including PSW #116 initiating the snack service to residents in the lounge area. At 1037hrs residents in the lounge had been served and the snack cart returned to the kitchen.

A tour of the home area hallway identified two residents #010 and #011 in their room whom had not been offered a beverage. Another resident, #012 identified in their room was asked if they were offered a beverage and the resident responded with a no.

An interview with PSW #116 confirmed that they had not offered resident's #010, #011, and #012 with a beverage and shared that on this unit staff were not allowed to go around to each resident's rooms and offer them cookies and drinks because of an issue with ants, that residents can choke and resident hoarding.

An interview with PSW #100 revealed that on this floor they have a rule that staff do not go down the hallway and serve residents in their rooms because of an ant issue in the resident rooms.

An interview with RN#105 shared that because of an ongoing issue with insects and mice they tried to control the food and drink at the front of the home area and that residents are called to come for tea and coffee to the lounge.

In separate interviews the Director of Dietary Services, RD and ADOC #104 were all unaware that staff were not offering all residents a between meal beverage and snack on Garden Unit and confirmed that the current practice was not consistent with the home's policy.

The licensee failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (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 residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids prepared in the food production system are served using methods which preserve taste, nutritive value, appearance and food quality.

This inspection was initiated related to a complaint, log #009362-18, revealing that texture modified foods were not appropriate and safe.

A review of the home’s policy Textured Food Production Policy #XI-F-10.80. Current revised date: March 2019 stated the following:

Pureed guidelines: Provide texture-modified foods with a smooth, homogeneous texture that require no chewing, are moist, semi-solid in consistency and form a cohesive bolus for swallowing.

-Instruct cooks to prepare minced and pureed foods just before serving to eliminate reheating and reduce holding time.

A tour of the kitchen was conducted with Cook #108 at 1430hrs on July 15, 2019. The inspector identified pans of food being held in the warming unit. The foods being held were confirmed to be prepared minced and pureed hot vegetables for dinner meal service. Dinner meal service begins at 1730hrs. An interview with Cook #108 revealed that minced and pureed vegetables were cooked, processed and hot held in the warming unit at 1330hrs each day prior to a morning dietary shift’s end of shift.

Dinner meal service was observed on July 17, 2019 in the Orchard home area dining room and the food served was taste tested.

All broccoli, regular, minced and pureed texture were overcooked, watery, gray in appearance and bland in flavour. Notable was the pureed broccoli which was watery and ran like the consistency of a liquid on the dinner plate into the other adjacent pureed foods.
The pureed shrimp, pureed salad and pureed beef wellington were also watery running into adjacent foods. These menu items tasted bland and watery in flavour.

Dietary aide #115 portioning the food at the servery described the broccoli as “overcooked” and confirmed that the pureed foods were runny and ran like the consistency of a liquid on the dinner plate. The dietary aide stated the kitchen staff used to have divider plates to prevent the foods from running into each other but the plates were removed from the kitchen last year.

An interview with the RD on July 23, 2019 at 1500hrs included an observation of the kitchen and hot holding unit which again contained pans of cooked minced and pureed

food.

The RD confirmed that extended hot holding of pureed foods negatively affected the nutritive value, flavour, texture and appearance of the foods. The RD also identified that pureed foods should be cohesive and hold its shape when staff are scooping it and not run on the dinner plate.

The home failed to ensure that all food prepared in the food production system was served using methods which preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

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 all food and fluids prepared in the food production system are served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

This IP was initiated related to two complaints, log #009362-18 and log #031669-18, which identified an ongoing lack of resident meal time feeding assistance.

A dinner meal service was observed on an identified home area during this inspection.

Resident #007, #008 and #009 were being totally assisted with feeding by PSW #111. The PSW was observed sitting on a stool between residents #007 and #008 then standing up, walking around the table and standing to feed resident #009. The PSW then returned back to a sitting position to feed resident's #007 and #008. This process was continuous during the meal observation period.

A separate table was observed with residents #004, #005 and #006 being totally assisted by PSW #112.

RPN #110 was present in the dining room and totally assisting two residents. An interview with RPN #110 confirmed that they were short staffed and confirmed staff were totally assisting three residents.

A record review of the written plans of care for all identified six residents observed confirmed their dependence on one staff member to assist them with feeding.

An interview with the RD further confirmed that the six identified residents required staff assistance with feeding and that the requirement was for one staff to only assist two residents at one time.

The home failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking. [s. 73. (2) (a)]

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 staff members assist only one or two residents at the same time who need total assistance with eating or drinking., to be implemented voluntarily.

Issued on this 27th day of August, 2019

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

Original report signed by the inspector.