

**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
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de
Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Sep 18, 2019	2019_565647_0022	016497-19	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

JENNIFER BROWN (647)

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): September 9 - 13, 2019.

The following intake was completed during the course of this Critical Incident System (CIS) inspection:

-one intake related to staff to resident abuse.

Complaint inspection #2019_565647_0021 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Nurse Practitioner (NP), Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed training documents, and policies and procedures.

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

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee 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 a Critical Incident Inspection (CIS) in the home, Inspector #647 had been observing resident #002 for specified interventions and strategies.

A review of resident #002's electronic plan of care indicated that resident #002 had been identified as a high risk of falls. The interventions in the plan of care indicated that resident #002 was required to have an identified interventions in place during all shifts.

During a documentation review of the progress notes and relevant assessments, in the time frame reviewed, it had been identified that resident #002 had multiple falls.

During observations of resident #002 on four occasions during this inspection period, the resident did not have the identified interventions in place.

During an interview with Personal Support Worker (PSW) #104, who provided direct care to resident #002 the morning of the first observation, indicated that they had access to the resident's Kardex and plan of care to be aware of their care requirements. When asked by Inspector #647, why the identified intervention was not applied to resident #002 as part of the morning care, PSW #104 indicated that they weren't sure if they were needed.

During interviews with Registered Practical Nurse (RPN) #105 and PSW #102, they indicated to Inspector #647 that resident #002 was identified as a high risk for falls.

In an interview with the Director of Care (DOC), they indicated that resident #002 was a high fall risk and a current intervention was to ensure resident #002 had the identified intervention in place during all shifts. The DOC further indicated that the care had not been provided as specified in the plan of care for resident #002. [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 care set out in the plan of care is provided to the resident as specified in the plan, specifically related to fall prevention interventions,, to be implemented voluntarily.

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.