Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2019	2019_832604_0030	018330-19, 022562-19	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

SHIHANA RUMZI (604), ASAL FOULADGAR (751)

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): December 5, 9, 10, 11, 12, 13, and 17, 2019.

During the inspection the following intake and follow-up was carried out:
-Intake log related to staff to resident alleged abuse
-Follow-up Compliance Order (CO) #001 submitted within inspection report #2019_565647_0021, served to the home on September 18, 2019, with a compliance date November 29, 2019

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Practical Nurse (RPN), Charge Registered Nurse (CRN), Personal Support Worker (PSW), and residents.

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, home's critical incident logs, staff training records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2019_565647_0021	604

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

Findings/Faits saillants :

The licensee has failed ensure 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 (MLTC) ACTIONline received a complainant alleging RPN #106 was prompted to call 911 as resident #007 appeared to be unwell which the RPN did not do and the RPN asked the complainant #100 who was also a PSW at the home to state they provided care to resident #007.

In an interview PSW#100 indicated during care for resident #007 they appeared to be unwell. The PSW stated PSW #105 left the identified area and got RPN #106 who arrived and provided care at which point the resident stabilized. The complainant stated they prompted the RPN to call 911 for assistance which they did not do as the resident started to appear unwell again.

In an interview PSW #105 stated they assisted PSW #100 with providing care to resident #007 at which point the resident appeared to be unwell. PSW #105 indicated they got RPN #106 who arrived and provided care to the resident and the two PSW staff prompted the RPN to call 911 which they did not do. The PSW stated once the RPN left the identified area resident #007 presented with the same symptoms and they ran to get the RPN at which point the ADOC #108 and Nurse Manager (NM) #107 arrived along with the paramedics.

In an interview RPN #106 stated PSW #100 and PSW #105 had asked them to assess resident #007 and they provided the care as needed. The RPN stated they called the SDM to indicate resident #007 was not well and would be transferring the resident to hospital, then called NM #107 who was informed they where transferring resident to hospital and then called 911. The RPN further stated they should have called 911 first.

In separate interviews Physician #121 and Director of Care (DOC) #102 indicated when RPN #106 observed resident #007 to be unwell and the RPN should have called 911 immediately. The Physician and DOC indicated resident #007's family had identified care which should have been provided which the RPN did not follow.

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 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act, and was complied with.

In Accordance with O.Reg 79/10, s. 230 (4) (v) of the regulation, the licensee is required to have an emergency plan for medical emergencies.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complainant alleging RPN #106 was prompted to call 911 as resident #007 appeared to be unwell which the RPN did not do and the RPN asked the complainant #100 who was also a PSW at the home to state they provided care to resident #007.

The home's policy titled "Emergency Management", policy #XVIII-A-20.00 with a current revision date as May 2016, indicates procedures for team members to follow when a resident, team member, or visitor is experiencing a medical emergency.

In an interview RPN #106 indicated specified procedure was to be followed when a resident was experiencing a medical emergency. The RPN stated that they did not implement the medical emergency procedure according to the homes policy.

In separate interviews with DOC #102 and ADOC #108 stated when resident #007 was experiencing a medical emergency RPN #106 did not follow the homes medical emergency policy.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act, and was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears, or wounds was assessed by a registered dietitian who was a member of the home, and any changes made to the resident's plan of care related to nutrition and hydration where implemented.

The home was served Compliance Order (CO) #001, within inspection report #2019-565647-0021, related to r.50 (2) (b) (ii). Resident #001 identified in the order had deceased and was replaced by resident #011 in order to carry out a follow-up inspection. Resident #011was identified as having altered skin integrity.

A review of resident #011's documentation did not show evidence of a Registered Dietitian (RD) assessing the resident for altered skin integrity.

In an interview RN #113, stated they assessed resident #011 and identified an alteration in skin integrity. The RN indicated an RD referral was to be sent out and acknowledge they did not carry out a referral to the RD as per the home's policy.

During an interview RD #114, indicated they were not aware of resident #011's altered skin integrity and did not receive a referral from registered staff to assess the resident.

An interview ADOC #101, stated when a resident is found to have an altered skin integrity, registered staff were to make a referral to RD as per the home's policy. The ADOC reviewed resident #011's documentation and acknowledged resident #011 was not assessed by the RD related to their altered skin integrity.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

The licensee has failed ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, (a) have the proper skills and qualifications to perform their duties.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complainant alleging RPN #106 was prompted to call 911 as resident #007 appeared to be unwell which the RPN did not do and the RPN asked the complainant #100 who was also a PSW at the home to state they provided care to resident #007.

The home's written job titled "Registered Practical Nurse", with a current revision date as May 2015, under job summary states as a valued member of the team the RPN demonstrates a commitment to residents' safety by providing quality care in accordance with the organization's vision and mission. Under education bullet number four states current Basic Cardiac Life Support (BCLS) certificate.

During an interview RPN #106, stated the home provides two CPR courses a year to all staff and indicated they do not have a valid BCLS as indicated in the RPN job title.

During an interview DOC #102 acknowledged RPN #106 did not have a valid BCLS as indicated in job title RPN.

Issued on this 6th day of January, 2020

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

Original report signed by the inspector.