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

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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
Feb 3, 2020	2020_718751_0002	023901-19, 023942-19	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

ASAL FOULADGAR (751)

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): January 22, 23, 24, 27, 28, 2020.

During this inspection the following intakes were inspected:
Two intakes related to Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector(s) observed residents, their home area, staff to resident interactions, and reviewed clinical health records, the home's investigation notes, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to protect resident #001 from physical abuse by resident #002 and

resident #003.
Physical abuse is defined by O.Reg. 79/10 as the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) indicating resident #001 was physically abused by resident #002 and required specific treatments for the injury they sustained as a result of this incident. The home submitted another CIS report to the MLTC indicating resident #001 sustained injuries due to being physically abused by resident #003. On the date the home submitted the latter CIS report, resident #001 noted to have injuries of unknown origin. The CIS report indicated resident #003 had self-reported an incident between themselves and an identified person which occurred in their room and caused the person to fall. During the home's investigation process, the home's camera footage was reviewed, and it was discovered that resident #001 had entered resident #003's room and was escorted out of the room by Personal Support Worker (PSW) #107 on an identified date and time. No injury was identified by PSW #107 at that time. A review of the home's CIS reports related to resident #001 indicated the resident was physically abused by various residents on previous occasions.

A review of resident #001's medical records indicated the resident was cognitively impaired. According to the most recent written plan of care, resident #001 had identified behaviors related to progression of their disease and was followed by internal and external behavioral support resources at the home. The resident required certain interventions in place to manage their identified behaviors.

A review of resident #002's medical record indicated the resident had cognitive impairment and was being followed by internal and external behavioral support resources at the home due to their responsive behaviors. A review of the resident's written plan of care indicated the staff were required to follow specific interventions to manage the resident's behavior.

A review of resident #003's medical record indicated the resident had borderline intact cognition and had identified behaviors. Further review of the resident's medical record indicated a previous incident between resident #003 and resident #001 within the past couple of months prior to the above reported incident.

Different interviews with PSW #100, #102, and #107, indicated resident #001 had cognitive impairment with an identified behavior and interventions were in place to

manage the resident's behavior to ensure their safety.

Related to physical abuse from resident #002 towards resident #001:
An interview with PSW #100 and #102 indicated resident #002 had cognitive impairment with identified responsive behaviors.

An interview with Registered Nurse (RN) #103, indicated that on the identified incident date, they were called by PSW #108, they responded immediately and found resident #001 with an identified injury which required a specific treatment. RN #103 further stated, PSW #108 reported that while they were assisting a co-resident in a specific area of the home, they observed the incident between resident #001 and resident #002 and by the time they intervened, resident #001 was already injured by resident #002. Inspector was unable to interview PSW #108 during the inspection process as the staff member was not available.

An interview with the home's Behavior Support Registered Practical Nurse (BSO RPN) #101, indicated that resident #002 had history of an identified behavior and interventions were put in place to prevent escalation of their behavior. BSO RPN #101 also indicated resident #001 had cognitive impairment and history of an identified behavior. BSO RPN #101 further stated staff were required to follow specific interventions to ensure resident #001's safety.

Related to physical abuse from resident #003 to resident #001:
In an interview with PSW #102, they indicated resident #003 had several responsive behaviors.
In an interview with resident #003, they were able to recall the incident between themselves and resident #001. Resident #003 further expressed general frustration about co-residents' behaviors similar to resident #001's behavior.

Interviews with RN #103 and RPN #104, indicated resident #003 had borderline cognitive impairment and was known to have identified responsive behaviors.
Interview with BSO RPN #101, indicated resident #003 was known to have responsive behaviors since early admission to the home, however they were not referred to the home's BSRT for an assessment prior to the incident that occurred between them and resident #001. BSO RPN #101 further indicated the resident had been monitored by the home's BSRT after the reported incident and an additional intervention was put in place for resident #001 to ensure their safety. BSO RPN #101, confirmed this intervention was put in place after the above incident occurred between resident #001 and resident #003.

Different interviews carried out with Associate Director of Care (ADOC) #105 and ADOC #106. ADOC #105 acknowledged resident #001 and #002 had cognitive impairments with history of responsive behaviors. ADOC #105 also acknowledged resident #003 had borderline cognitive impairment according to their CPS score and had identified responsive behaviors according to the progress notes. The documented incident between resident #001 and resident #003 which occurred a couple of months prior to the reported incident was also reviewed with ADOC #105. ADOC #105 acknowledged previous incidents when the home had reported resident #001 was physically abused by different co-residents. ADOC #105 acknowledged that the resident was not protected from abuse in the above-mentioned incidents.

The home failed to protect resident #001 from physical abuse by resident #002 and #003 as they were known to have history of responsive behaviors. Interventions to ensure resident #001's safety regarding their specific behavior were ineffective. [s. 19. (1)]

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 protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that the plan of care for resident #003, was based on an interdisciplinary assessment of the resident that included any mood and behavior patterns, any identified responsive behaviors, and any potential behavioral triggers.

The home submitted a CIS report to the MLTC indicating resident #001 sustained injuries due to being physically abused by resident #003. On the date the home submitted the CIS report, resident #001 noted to have injuries of unknown origin. The CIS report indicated resident #003 had self-reported an incident between themselves and an identified person which occurred in their room and caused the person to fall. During the home's investigation process, the home's camera footage was reviewed, and it was discovered that resident #001 had entered resident #003's room and was escorted out of the room by Personal Support Worker (PSW) #107 on an identified date and time. No injury was identified by PSW #107 at that time. A review of the home's CIS reports related to resident #001 indicated the resident was physically abused by various residents on previous occasions.

A review of resident #003 medical record indicated they were admitted to the home with identified diagnosis and their CPS score indicated borderline intact cognition. A Review of the behavior progress notes during an identified period, indicated resident had multiple responsive behaviors. Further review of the resident's medical record indicated a previous incident between resident #001 and resident #003. A review of resident #003's written plans of care completed prior and after the reported CIS, did not indicate any of the resident's behaviors.

Multiple interviews carried out with PSW #100 and #102, the home's BSO RPN #101, and RN #103, indicated the resident's mood and behavior patterns were not identified in the resident's written plan of care. During an interview with BSO RPN #101, they stated they did not receive a referral related to the resident's exhibited responsive behaviors.

In an Interview with Associate Director of Care (ADOC) #105, they reviewed resident #003's written plan of care and acknowledged the resident's behaviors were not identified in their plan of care. The home failed to ensure that resident #003 who had exhibited responsive behaviors was assessed, their mood and behavior patterns were identified, and any potential behavior triggers were noted in the plan of care. [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 a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 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, to be implemented voluntarily.

Issued on this 6th day of February, 2020

[redacted]

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

Original report signed by the inspector.