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 |
|---|---|---|---|
| Feb 12, 2021 | 2021_823653_0005 | 022304-20, 022306-20, 001957-21 | Follow up |

## 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

ROMELA VILLASPIR (653)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): February 8, 9, and 10, 2021.**

**During the course of the inspection, the following intakes were inspected:**

**Follow-up log #022304-20, CO #003 issued on October 23, 2020, within report #2020_669642_0016, related to the LTCHA, 2007, s. 20 (1).**

**Follow-up log #022306-20, CO #001 issued on October 23, 2020, within report #2020_669642_0016, related to the LTCHA, 2007, s. 19 (1).**

**Follow-up log #001957-21, CO #001 issued on January 29, 2021, within report #2021_838760_0003, related to the O. Reg. 79/10, s. 229 (4).**

**During the course of the inspection, the inspector toured the home, observed staff to resident interactions, Infection Prevention and Control (IPAC) practices, reviewed clinical health records, the home's compliance binder, and staff education records.**

**During the course of the inspection, the inspector(s) spoke with the Care Support Assistants (CSAs), Housekeepers (HKs), Physiotherapy Assistant (PTA), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Human Resources (HR), Director of Care (DOC), and the Executive Director (ED).**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2020_669642_0016 | 653 |
| LTCHA, 2007 S.O. 2007, c.8 s. 20. (1) | CO #003 | 2020_669642_0016 | 653 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home was issued a compliance order on January 29, 2021, within report #2021_838760_0003, related to O. Reg. 79/10, s. 229 (4), with a compliance due date of February 5, 2021. A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program during the on-going respiratory outbreak.

During the on-site inspection, the following observations were conducted by Inspector #653:
-Care Support Assistant (CSA) #108 entered and exited from several resident rooms, including one that was on contact precautions. The CSA delivered clothing protectors, and picked up used ones, without performing hand hygiene in between resident environment contact.
-Registered Practical Nurse (RPN) #109 was in the dining area, and did not perform hand hygiene in between contact with three residents.
-Personal Support Worker (PSW) #112 entered and exited from three resident rooms, and helped set up a resident’s meal by opening the disposable food containers, without performing hand hygiene in between resident environment contact.
-A resident room was on droplet/ contact precautions; PSW #114 was only wearing eye protection and face mask while they were inside the room and in close proximity with the resident. After seeing the inspector in the hallway, the PSW exited the room, and performed hand hygiene. The PSW proceeded to taking a new gown, tied the neck part, and donned the gown over their eye protection and face mask.
-A resident room was on droplet/ contact precautions; Housekeeper (HK) #115 was in full Personal Protective Equipment (PPE) while cleaning inside the room. The HK exited from the room in full PPE, and continued cleaning in the hallway and proceeded to cleaning in two other resident rooms, without properly donning and doffing the appropriate PPE.
-A room was on droplet/ contact precautions, and an unrolled yellow disposable gown was hanging on the door.
-A room was on contact precautions; PSW #102 was in the process of donning their gloves, and they tucked their gloves under the wrist of the yellow disposable gown, instead of extending the gloves to cover the wrist of the gown.
-Physiotherapy Assistant (PTA) #100 exited from two resident rooms carrying heating pads, and proceeded to exiting through the fire doors, without performing hand hygiene.

During a joint interview with the Director of Care (DOC) and the Executive Director (ED), both acknowledged the inspector’s observations, and the DOC indicated that the risk or

potential negative outcome that would result from the staff not adhering to the proper IPAC practices would be cross contamination.

Sources: Observations; Interviews with the DOC, ED, and other staff. [s. 229. (4)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 12th day of February, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**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**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROMELA VILLASPIR (653) |
| **Inspection No. / No de l'inspection :** | 2021_823653_0005 |
| **Log No. / No de registre :** | 022304-20, 022306-20, 001957-21 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Feb 12, 2021 |
| **Licensee / Titulaire de permis :** | The Royale Development GP Corporation as general partner of The Royale Development LP<br>302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Bradford Valley Care Community<br>2656 6th Line, Bradford, ON, L3Z-2A1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Cathy VanBeek |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2021_838760_0003, CO #001;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

**Order / Ordre :**

The licensee must be compliant with s. 229 (4) of the O. Reg. 79/10.

Specifically, the licensee must:
1. Conduct monitoring in all home areas to ensure staff are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with the appropriate IPAC measures.

**Grounds / Motifs :**

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_838760_0003 issued on January 29, 2021, with a compliance due date of February 5, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program during the on-going respiratory outbreak.

During the on-site inspection, the following observations were conducted by Inspector #653:
-Care Support Assistant (CSA) #108 entered and exited from several resident rooms, including one that was on contact precautions. The CSA delivered clothing protectors, and picked up used ones, without performing hand hygiene

in between resident environment contact.
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-Physiotherapy Assistant (PTA) #100 exited from two resident rooms carrying heating pads, and proceeded to exiting through the fire doors, without performing hand hygiene.

During a joint interview with the Director of Care (DOC) and the Executive Director (ED), both acknowledged the inspector's observations, and the DOC indicated that the risk or potential negative outcome that would result from the staff not adhering to the proper IPAC practices would be cross contamination.

Sources: Observations; Interviews with the DOC, ED, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because some staff

continued to be non-compliant with the proper IPAC measures during the outbreak, which may possibly lead to cross contamination.

Scope: The scope of this non-compliance was a pattern because the IPAC related concerns were observed in four of the eight units at the home.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #001 was issued on January 29, 2021, (Inspection 2021_838760_0003) with a compliance due date of February 5, 2021. (653)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 26, 2021

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 12th day of February, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Romela Villaspir

**Service Area Office /**
**Bureau régional de services :** Central East Service Area Office