Original Public Report

Report Issue Date June 10, 2022
Inspection Number 2022_1389_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royale Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Bradford Valley Care Community, Bradford

Lead Inspector
Amandeep Bhela (746)

Additional Inspector(s)
Britney Bartley (732787), Ama Agyemang (722469)

Inspector Digital Signature
Amandeep Bhela
2022.06.13 13:55:10 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 4-6, 9-10, 2022

The following intake(s) were inspected:

- Intake: 005478-22 related to falls.
- Intake: 000824-22 related to falls.
- Intake: 000406-22 related to falls.
- Intake: 016446-21 related to transfers.

- The following intakes were completed in the Critical Incident System Inspection: Log #006420-22, Log# 003239-22, Log# 019843-21 which were related to falls.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION [POLICIES AND RECORDS]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 8 (1)

The licensee had failed to ensure that the policy and procedures included in the required Pain Management Program were complied with, for resident #003.

O. Reg. 79/10, s. 52 (1) (2) requires that the program includes strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

Rational and Summary

On January 3, 2022, resident # 003 sustained a fall and was found in their bedroom by RPN #122. On initial assessment, the resident sustained injuries. On an identified date, staff #123's documentation indicated the resident complained of pain to an identified area. At the time of the incident the resident was not taking scheduled routine pain medication. DOC confirmed pain was identified for resident #003 on January 3, 2022, and was not given anything to alleviate the pain post fall. Failing to not do any pain releveling intervention, resulted in resident having unrelieved pain.

Sources: clinical record review of resident #003, observations, Pain Management Program Procedure (VII-G-30.30) revised April 2019 and interviews with staff #122, #123 and the DOC. [732787]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg 246/22, 272

Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* are followed in the home.

Rational and Summary

It was identified on a home area that staff #100 was observed wearing a face shield and surgical mask, the surgical face mask was below their nose and chin. ADOC confirmed staff #100 was not wearing the surgical mask as required by CMOH Directive #3. Failing to wear the surgical mask appropriately increase the risk of transmitting COVID.

Sources: observations and interview with ADOC # 109. [732787]

WRITTEN NOTIFICATION [Transferring and positioning techniques]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O.Reg 79/10, s.36

The licensee had failed to ensure that staff used safe transferring and positioning techniques when assisting resident #001.

Rational and Summary

On an identified date, resident #001 was being transported in their wheelchair by staff #101. As the resident was being assisted back to their room, resident #001 sustained an injury. On an identified date, resident #001 was sent out to the hospital, unrelated to the incident, where it was confirmed that the resident sustained at injury to an identified location.

Interview with staff#101 indicated that this was the first time they had worked with resident #001 and that they should have ensured the resident was correctly positioned in the prior to transporting. Staff #101 and ADOC #109 acknowledged that failing to ensure that safe transferring and positioning techniques are used when assisting residents can put them at risk for injury.

Sources: Clinical records for resident #001, interview with staff #101 and ADOC #109. [746]

WRITTEN NOTIFICATION [POLICIES AND RECORDS]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 8(1)(b)

The licensee has failed to ensure that the Falls Risk Assessment was completed in accordance with the requirements of the home's Falls policy.

Rationale and Summary

The home's Falls Prevention & Management policy, revised December 2021, indicates for a falls risk assessment to be completed on admission and re-admission to the home, and when there is a change in a resident's status. Resident #004 had a fall with injury which resulted in transfer to hospital. Upon return to the home, a falls risk assessment was not completed. ADOC #124 and RPN #113 both stated that a falls risk assessment would not be completed post fall for resident #004 because they were already assessed as high risk for falls. ADOC confirmed that indication of a resident's falls risk status would be documented in the resident's care plan. Review of the resident's care plan did not indicate a falls risk level indicated for resident #004. Review of the last Falls Risk Assessment, completed on an identified date indicated resident #004 to be at moderate risk for falls. ADOC later confirmed that falls risk assessment should be completed on admission and re-admission and should have been completed for resident #004 upon return from hospital.

The falls risk assessment not completed as indicated impedes identification of changes in the risk status and appropriate interventions for falls management. This could further increase the risk and frequency of falls for the resident.

Sources: interviews with ADOC and RPN #113, Falls Prevention & Management policy, resident #004's care plan, MDS assessment, progress notes and Falls Risk Assessments.

[722469]