Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2013	2013_109153_0019	T-80-13, T-105-13	Complaint

Licensee/Titulaire de permis

SPECIALTY CARE - BRADFORD INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

Long-Term Care Home/Foyer de soins de longue durée

BRADFORD VALLEY
2656 6th Line, Bradford, ON, L3Z-3H5

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

LYNN PARSONS (153)

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): August 14, 15,16, 2013.

During the course of the inspection, the inspector(s) spoke with Director of Clinical Services(DOC), Assistant Director of Care(ADOC), Registered Nurse (RN), Registered Dietitian(RD), Director of Nutritional Services, Personal Support Workers(PSWs) and Substitute Decision Makers(SDMs).

During the course of the inspection, the inspector(s) reviewed clinical health records and home policies related to Nutrition, Oral Care and Fall Prevention. Completed observations of staff to resident interactions, provision of care and snack carts.

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

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee did not ensure the written plan of care set out clear directions to staff and others who provide direct care to the resident.
The written plan of care for Resident #4 did not address the following areas identified during staff interviews and record review:
- frequent urinary tract infections
- staff to speak into resident's right ear as a result of a hearing deficit
- ensure resident is removed from the dining room after meals
- assist resident to bed for a rest
The written plan of care contains conflicting information related to toileting and continence care.
Under the toileting section it indicates 1 staff required for extensive assistance and brief change while under the bladder section it indicates the resident required supervision.
When interviewed the Director of Clinical Services confirmed the written plan of care did not provide clear direction. [s. 6. (1) (c)]

2. The licensee did not ensure that different approaches are considered in the revision of the plan of care when the care set out in the plan has not been effective.
Resident #4 experienced 11 falls during the period of June 25 to September 13, 2012.
A review of the Post Fall assessments revealed only one occasion whereby a different approach was implemented to prevent another fall that being to assist the resident into bed for a rest.
When interviewed the Director of Clinical Services confirmed the interventions for fall prevention were the same for both the June and September plans of care. [s. 6. (11) (b)]

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 written plans of care provide clear direction to staff and others who provide direct care to the residents
- different approaches are considered in the revision of the plan of care when the care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 1st day of October, 2013

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

Lynn Parsons