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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
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Bureau régional de services de Toronto
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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
Jan 7, 2014	2013_168202_0063	T-692-13	Critical Incident System

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

VALERIE JOHNSTON (202)

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): November 27, 28, 29, December 02, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Assistant Director of Care, Staffing Scheduler, Registered Nursing Staff, Dietary Aide, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed staffing schedule for October and November 2013, reviewed the home's policies related to prevention of abuse and responsive behaviours

The following Inspection Protocols were used during this inspection: Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 55. Behaviours and altercations

Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55 (a)].

A review of resident #002's plan of care identifies this resident as having responsive behaviours. A review of resident #002's progress notes for an identified period of time revealed nine documented incidents of aggression toward residents and staff. On an identified date, resident #002 pushed resident #001 resulting in injury requiring surgical repair and later passed away.
The physician orders for resident #002 were reviewed. On an identified date the physician ordered 1:1 supplemental staffing as an intervention to monitor resident #002's unstable and aggressive behaviours for an identified period of time. The order for 1:1 supplemental staffing was reordered twice for resident #002's continued aggression and instability. Staff interviews revealed that resident #002 is very unpredictable and the only way to minimize the risk to residents and staff was to have 1:1 staffing supplied. Staff indicated that resident #002 did not receive 1:1 supplemental staffing daily and for each shift as ordered. Staff indicated that 1:1 staffing was supplied sporadically and the 1:1 staffing intervention ordered by the physician was not taken seriously. A review of the staffing schedule for an identified period of time revealed that resident #002 was not provided 1:1 staffing for each shift for twelve identified dates.
The Acting Director of Care (ADOC) confirmed that 1:1 supplemental staffing intervention for resident #002 was not provided on the above identified dates and 1:1 staffing was only provided on days when there was an extra staff member in the home. The ADOC revealed that 1:1 supplemental staffing would be scheduled for each shift, however if the supplemental staff member is required to work elsewhere in the home due to staff shortages, the staff member is pulled to the area most needed. The ADOC indicated that although resident #002 was considered high risk, staffing the home appropriately was the main concern.
The progress notes for resident #002 were reviewed for an identified period of time revealed eight documented incidents of aggression. The eight documented aggressive incidents occurred during shifts when the 1:1 supplemental staffing was not available or pulled to be used elsewhere in the home. An interview with the ADOC confirmed that the 1:1 supplemental staffing intervention ordered by the physician to monitor resident #002's unstable and aggressive behaviours had not been implemented fully.

Additional Required Actions:

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

WN #2: 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 :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6. (7)]

A review of resident #002's plan of care identifies this resident as having responsive behaviours. Resident #002's physician orders for an identified period of time were reviewed. On an identified date the physician ordered 1:1 supplemental staffing for an identified period of time to monitor resident #002's unstable and aggressive behaviours. The order for 1:1 supplemental staffing was reordered twice for resident #002's continued aggression and instability. A review of the staffing schedule for the identified period of time revealed that resident #002 was not provided 1:1 supplemental staffing for each shift on twelve identified dates.
The Acting Director of Care (ADOC) confirmed that 1:1 supplemental staffing for resident #002 was not provided on the identified dates and 1:1 supplemental staffing was only provided on days when there was an extra staff member in the home. The ADOC confirmed that resident #002 was not provided 1:1 staffing as in accordance to resident #002's plan of care. [s. 6. (7)]

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

Issued on this 7th day of January, 2014

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

Valerie Johnston

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2013_168202_0063
Log No. / Registre no:	T-692-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 7, 2014
Licensee / Titulaire de permis :	SPECIALTY CARE - BRADFORD INC. 400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUANNE CAMPEAU

To SPECIALTY CARE - BRADFORD INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents. Please submit plan to valerie.johnston@ontario.ca by January 31, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55 (a)].

A review of resident #002's plan of care identifies this resident as having responsive behaviours. A review of resident #002's progress notes for an identified period of time revealed nine documented incidents of aggression toward residents and staff. On an identified date, resident #002 pushed resident #001 resulting in injury requiring surgical repair and later passed away.

The physician orders for resident #002 were reviewed. On an identified date the physician ordered 1:1 supplemental staffing as an intervention to monitor resident #002's unstable and aggressive behaviours for an identified period of time. The order for 1:1 supplemental staffing was reordered twice for resident #002's continued aggression and instability. Staff interviews revealed that resident #002 is very unpredictable and the only way to minimize the risk to residents and staff was to have 1:1 staffing supplied. Staff indicated that resident #002 did not receive 1:1 supplemental staffing daily and for each shift as ordered. Staff indicated that 1:1 staffing was supplied sporadically and the 1:1 staffing intervention ordered by the physician was not taken seriously. A review of the staffing schedule for an identified period of time revealed that resident #002 was not provided 1:1 staffing for each shift for twelve identified dates.
The Acting Director of Care (ADOC) confirmed that 1:1 supplemental staffing intervention for resident #002 was not provided on the above identified dates and 1:1 staffing was only provided on days when there was an extra staff member in the home. The ADOC revealed that 1:1 supplemental staffing would be scheduled for each shift, however if the supplemental staff member is required to work elsewhere in the home due to staff shortages, the staff member is pulled to the area most needed. The ADOC indicated that although resident #002 was considered high risk, staffing the home appropriately was the main concern.
The progress notes for resident #002 were reviewed for an identified period of time revealed eight documented incidents of aggression. The eight documented aggressive incidents occurred during shifts when the 1:1 supplemental staffing was not available or pulled to be used elsewhere in the home. An interview with the ADOC confirmed that the 1:1 supplemental staffing intervention ordered by the physician to monitor resident #002's unstable and aggressive behaviours had not been implemented fully.
(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of January, 2014

Signature of Inspector / Signature de l'inspecteur : Valerie Johnston

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

Service Area Office / Bureau régional de services : Toronto Service Area Office