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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2016_393606_0018	033374-16	Resident Quality Inspection

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

Bloomington Cove Care Community
13621 Ninth Line Stouffville ON L4A 7X3

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

JANET GROUX (606), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 30, December 1, 2, 5, 6, 7, 8, 9, 12, 13, 2016.

The following intakes were inspection concurrently with the RQI:
Two Complaints related to staffing issues.
Critical Incidents related to a resident fall resulting in a fracture to the left hip and related to improper transfer of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Environmental Manager (DEM), Handyman, Physiotherpist Assistant (PTA), Recreational Therapist (RT), Housekeeping Aide (HA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Maker (SDM), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, Family Council (FC) questionnaire, minutes of the Residents' Council (RC) meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Sufficient Staffing

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

5 WN(s)
4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Review of an identified CI reported resident #010 fell resulting in a transfer to the hospital and diagnosed with a medical condition.

Review of resident #010's progress notes indicated the resident had a fall on an identified date and time and was found on the floor in an identified position in front of the nursing station. Further review indicated resident #010 was able to get up by him/herself and a chair was offered for him/her to sit on, however, resident #010 continued to walk around without his mobility aide and indicated the resident was in an identified state, and had refused to use his/her mobility aide. The progress notes indicated upon assessment of resident #010's change in condition and review of his/her plan of care revealed current fall prevention interventions to manage his/her falls and a new intervention of encouraging resident to use his/her mobility aide was indicated.

Review of documentation in the progress notes by the physiotherapist on an identified date as a follow up to the fall on an identified date revealed resident #010 remained a high fall risk due to his/her identified behaviours, and one of the recommendations was the need for resident #010 to be reminded to use his mobility aide for all mobility. It indicated the resident will need constant cues to use the mobility aide and must be supervised for safe ambulation.

Review of resident #010's plan of care last reviewed on an identified date indicated he/she was at risk for falls characterized by a history of falls and injury, and multiple risk factors related to use of an identified type of medications, behaviours and had been

diagnosed with a medical condition on an identified date. The plan of care states that staff are to encourage resident to use his/her mobility aide.

Interview with PSW #110 revealed he/she was aware resident #010 was at high risk for falls and stated the direction provided to staff was to monitor him/her because the resident will get up and walk. The PSW was not aware the plan of care also directed staff to remind the resident to use his/her mobility aide when ambulating and that resident #010 required constant cueing to use his/her mobility aide.

Interviews with RPN# 104 and the DOC indicated the home's practice is to ensure staff are aware of the resident's plan of care.

The licensee failed to ensure that the staff and others who provide direct care to resident #010 were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

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 ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

During stage one of the Resident Quality Inspection (RQI) resident #003 triggered for potential for an identified restraint. The inspector observed on November 30, 2016, resident #003's bed to have two identified assistive device in an identified position.

Review of the home's policy entitled, "Personal Assistance Service Devices (PASDs)", #V11-E-10.10 revised November 2015, indicated all registered staff will evaluate the use of PASDs quarterly using the Restraint/PASD electronic assessment form.

Review of resident #003's identified medical records revealed a quarterly Restraint/PASD Assessment was completed on two identified dates. A quarterly Restraint/PASD Assessment was not identified for the period between these dates in the record review.

Interviews with PSW #101 and #125 confirmed the identified assistive device were used for repositioning and when he/she was receiving care by staff. RPN #102 revealed residents are assessed quarterly for the use of a PASD to evaluate and determine its effectiveness. RPN #102 confirmed resident #003 used an identified assistive device as a PASD to hold onto when staff was providing care. RPN #102 acknowledged resident #003 did not have a quarterly assessment of his/her identified assistive device completed in July 2016.

Interview with the DOC identified the home's process for assessing a resident's use of a PASD including the identified assistive device was to be completed on a quarterly basis and the assessment would be included in Point Click Care (PCC).

The home failed to ensure compliance with their policy requiring quarterly assessment of the use of a PASD for resident #003. [s. 8. (1) (b)]

2. During stage one of the RQI resident #003 triggered for potential for an identified restraint. The inspector observed on December 1, 2016, resident #005's bed had a an identified assistive device in an identified position.

Observations during the course of this inspection identified the assistive devices on an identified location of resident #005's bed were in an identified position on December 7, 8, and 12, 2016.

Review of the home's policy entitled, "Personal Assistance Service Devices (PASDs)", #V11-E-10.10 revised November 2015, indicates all registered staff will evaluate use of PASDs quarterly using the Restraint/PASD electronic assessment form.

Review of resident #005's electronic medical records revealed a quarterly Restraint/PASD Assessment had not been completed since he/she was admitted on an identified date.

Interviews with PSW #121 and #103 identified the use of the identified assistive device in resident #005's care plan for repositioning and when resident was provided care by staff. RPN #126 revealed residents are assessed quarterly for the use of a PASD to evaluate and determine its effectiveness. RPN #126 confirmed resident #005 used the identified assistive devices as a PASD to hold onto when staff were providing care to him/her. RPN #126 acknowledged resident #005 did not have any assessment completed for the use of the identified assistive devices.

Interview with the DOC identified the home's process for assessing a resident's use of a PASD including side rails was to be completed on a quarterly basis and the assessment would be included in PCC.

The home failed to ensure compliance with the home's policy requiring quarterly assessment of the use of a PASD for resident #005. [s. 8. (1) (b)]

3. During stage one of the RQI inspection, resident #004 triggered to have had a fall in the last 30 days triggered through a staff interview and the most recent Minimal Data Set (MDS) assessment.

Review of the home's policy entitled, "Head Injury Routine", #V11-G-10.40 revised on January 2015, indicated that any resident who has sustained or is suspected of sustaining a head injury; and after any unwitnessed resident fall directs staff to complete Head Injury Routine (HIR) as per the schedule outlined or as ordered by the Physician. The HIR indicated resident will be monitored for 15 minutes for the first hour (hr), 30 minutes for two hrs, hourly for the next three hrs, every two hrs for the eight hrs, and every four hrs for 12 hrs or until directed by the physician to cease monitoring.

Review of resident #004's progress notes and an identified home's report on an identified date indicated the resident was found on the floor at an identified time and location of the unit.

Interview with RPN # 104 revealed the fall was unwitnessed and indicated resident #004 was assessed and sustained an alteration in skin integrity to an identified area of his/her body. Further assessment indicated resident was alert but confused and was unable to recount the details of the incident. He/she stated resident #004 was placed on HIR and monitored for 15 minutes for the first hr, thirty minutes for the next two hrs and was last monitored at an identified time because he/she assessed the resident to be stable and confirmed he/she did not collaborate with the physician in making the decision to discontinue the HIR.

Interview with the DOC confirmed the above mentioned home's policy directs registered staff to contact and collaborate with the physician before discontinuing a HIR and this was not followed. [s. 8. (1) (b)]

4. Review of the RQI inspection stage one assessment indicated resident #002 to have a potential for an identified restraint triggered by an observation by the inspector. It was observed resident #002's had his/her identified assistive devices in an identified position.

“PASD” means personal assistance services device, being a device used to assist a person with a routine activity of living.

Review of resident #002's plan of care on an identified date indicated the resident required an identified PASD to assist with routine activities of daily living (ADL's) as a turning and repositioning aid while in bed and directed the staff to ensure an identified assistive device to be used while in bed.

Review of the home's policy entitled, "Personal Assistance Service Devices (PASD's)", #V11-E-10.10 revised November 2015, indicated the registered staff to evaluate the use of PASDs quarterly and any other time when a PASD is no longer required based on the resident`s condition or circumstance using the Restraint/PASD electronic assessment form.

Review of resident #002's PCC assessments indicated no records that the resident's PASD had been assessed quarterly in 2016.

Interview with RPN #102 revealed it was the responsibility of the registered staff to complete a quarterly assessment of any resident with a PASD and stated the home has a schedule that notified the registered staff when a resident required a PASD assessment. The RPN stated resident #002's PASD assessments were missed in 2016 and therefore were not completed.

Interview with the DOC confirmed that PASD's such as bed rails are assessed quarterly or anytime there is a change in the resident's needs and/or condition. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the home was maintained in a safe condition and in a good state of repair.

During the initial home tour of the home on November 30, 2016, the following

observations were made:

Shower room located in an identified home area and floor:
- a grab bar on a tiled wall was projecting out of the wall and hanging loosely and was visible to anyone that it was becoming unhinged from the wall. The inspector touched the grab bar and confirmed the grab bar was not secured into the shower wall;
-several tiles located near the bottom of the shower wall were observed to be chipped, cracked, and crumbling, and were in disrepair;
- a hole measuring approximately 1.5 inches x 1.0 inches was noted in the wall between two identified rooms exposing the structure through the drywall.

Shower room located in an identified home area and floor:
- an 'L' shaped handle bar next to the shower head was loose and was coming off the wall tiles;
- tiling under a horizontal grab bar on the adjacent wall in the shower area was observed to be cracked and crumbling tiles were noted on bottom of the wall towards the floor.

The home initiated repairs for the shower grab bars and tiles in the identified shower rooms immediately upon being informed by the inspector. The inspector confirmed through observation made on December 2, and 3, 2016, that the repairs had been completed.

The hole in the wall on an identified home area remained in disrepair until December 9, 2016, when the inspector identified the damaged wall to housekeeping aide #122 during an interview.

Review of the home's preventative maintenance program policies and procedures revealed:
- a policy entitled "Preventative Maintenance Program", revised January 2015, identified the home's preventative maintenance program would include regular and scheduled audits of fixtures in the home;
-a "Physical Plant Audit Form" which identified a checklist of all home areas and related items to be assessed during a monthly audit which was to be completed by the ESM and
-a policy entitled "Work Order Requisitions", revised January 2015, identified that all staff would complete a requisition with a full description of the work requested.

Interviews with HA #122, PSW #103, PSW#118, and PSW#121 reported that all staff in the home used the maintenance system on their workstation computers to submit

requests to the maintenance department on an ongoing basis. They revealed they were unaware of the loose grab bars in the shower rooms of an identified home area. During the interview with housekeeping aide #122, he/she acknowledged the damaged wall had not been identified to maintenance.

Interview with the ESM revealed the he/she was unaware of the grab bars, and chipped tiles, or the hole in the wall in the two identified home areas. The ESM reported he/she will conduct routine walkabouts and make visible observations that would be included in monthly maintenance audits. The ESM was unable to demonstrate that a 'Physical Plant Audit Form' was completed for two identified months and acknowledged the grab bars, chipped tiles, and the hole in the wall had not been identified for repair by anyone until the inspector brought it to the attention of the home. The ESM acknowledged the grab bars had place residents at risk for harm and injury.

Interview with the Administrator revealed the home's process for identifying and communicating repair needs included the use of the online maintenance task platform and is accessible to all staff in the home. He/she confirmed the home's process for identifying maintenance needs had not been implemented in relation to the items identified in this inspection. [s. 15. (2) (c)]

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 ensure the home was maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Review of an identified CI reported a staff member was portering resident #008 from his/her room to the dining room in his/her wheelchair, the resident dropped his/her feet down to the floor in an attempt to stop the wheelchair from moving because he/she did not want to go to the dining room. The sudden stop resulted in his/her feet and leg to hit the wheelchair base and resulted in the resident being transferred to the hospital with a medical condition.

Review of resident #008's progress notes on an identified date and time indicated PSW #103 went to resident #008 to assist him/her to the dining room for his/her meal. It indicated resident was able to propel him/herself in the wheelchair independently using his/her legs. While being portered to the dining room, PSW #103 stated the resident suddenly stopped the wheelchair and screamed and verbalized pain to an identified area of his/her body. Resident #008 was assessed by RPN #109 and observed no injury at the time. He/she obtained orders from the physician for the resident to receive an identified treatment to the identified area of his/her body and for staff to continue to monitor.

At an identified time, resident #008's was assessed by the physician and was transferred to the hospital due to resident verbalizing pain to an identified area of his/her body and was assessed to have swelling to the identified area of his/her body. The home was notified by resident #008's SDM that the resident was diagnosed with a medical condition to two areas of his/her body and was scheduled for surgery.

Review of resident #008's plan of care initiated on an identified date indicated resident is able to self propel for short distances in the wheelchair using his/her upper extremities. It directed staff to ensure resident #008 has his/her hands on the track bar to self propel and not the spokes to prevent the risk for his/her hands from getting caught. The plan of care further revealed the resident will need one staff to assist him/her for long distances in the wheelchair and total assist for off unit locations. The plan of care directed staff to have an identified mobility aide on his/her wheelchair at all times except during transfer in and out of chair.

Interview with resident #008 was not conducted due to an identified diagnosis.

Interview with the SDM revealed he/she was informed by the home that resident was being portered to the dining room when had suddenly dropped his/her foot on the ground and screamed of pain to an identified area of his/her body. The SDM stated that resident #008 was being portered without the identified mobility aide to his/her wheelchair and

believed the home should have had the identified mobility aide when portering him/her from her room which was located the end of the hallway and was not close to the dining room.

Interview with the PSW #103 and RPN#109 revealed that the resident does not always like going to the dining room and would sometimes refuse to go and during these times staff would need to go to the resident's room and encourage him/her to go to the dining room. They stated the resident was assisted during the identified time to go to the dining room and stated the resident was compliant with being portered. PSW #103 stated the resident had refused to go to the dining room in the past and had put his/her feet down to attempt to stop the wheelchair from moving. The PSW stated the resident did not require the identified mobility aide in his/her wheelchair prior to the incident because resident #008 used his/her feet to propel the wheelchair to move around. The PSW stated that the resident will put his/her feet down all the time when we are pushing him/her and you have to be really careful. The PSW further stated that the resident is no longer able to put his/her feet down, now that he/she has the identified mobility aide on his/her wheelchair.

Interview with the PTA revealed resident #008 is able to self propel his/herself with his/her feet at the time of the incident and was able to take directions with keeping his/her feet up while being portered however for resident safety staff should always put the identified mobility aide on when portering the resident in his/her wheelchair. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee shall ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

Review of an identified CI reported resident #008 sustained an injury while being portered by a staff member in his/her wheelchair to the dining room resulting in resident being transferred to the hospital for surgery due to a medical condition.

Review of resident #008's progress notes revealed the SDM had notified the home at an identified date and time that the resident had been diagnosed with a medical condition and was scheduled for surgery.

Further review of the home's CI records indicated the incident occurred on an identified date and time but the CI report was not submitted by the home until an identified date and time, four business days later.

Interview with the DOC stated that he/she believed the legislation provided three days rather than one day and confirmed that the CI submission was four days late. [s. 107. (3) 4.]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.