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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 11, 2018 | 2018_414110_0005 | 004984-18 | 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 3C8

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

DIANE BROWN (110), JOVAIRIA AWAN (648), SARAH GILLIS (623), SARAN DANIEL-DODD (116)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): March 21, 22, 23, 26, 27, 28, 29. April 3, 4, 2018.**

**The following were completed in conjunction with the RQI:**
**Complaints:**
**Log # 020988-17 related to insufficient staffing.**
**Log # 025844-17 related to improper transferring.**
**Log #028478-17 related to improper care and insufficient staffing.**
**Log #004444-18 related to plan of care and insufficient staffing.**
**Follow-up:**
**Log # 020307-17 related to order #001, LTCHA, 2007, s. 19 (1) related to duty to protect from abuse and neglect.**
**Log #020308-17 related to order #002, LTCHA, 2007, s. 36 related to improper transfers.**

**During the course of the inspection, the inspector(s), conducted a tour of the home, reviewed clinical records, observed residents and staff to resident interactions including a medication administration.**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), RAI Coordinator, Behavioral Support Registered Practical Nurse, Behavioral Support Recreation Therapist, Clinical Care Partner, Registered Nurses, Personal Support Worker, Recreation Therapist**

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

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **0 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 | 2017_644507_0008 | 110 |
| O.Reg 79/10 s. 36. | CO #002 | 2017_644507_0008 | 116 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

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

**s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On August 2, 2017, compliance order (CO) #001, made under LTCHA 2007, c. 8, s. 19. (1) during Inspection #2017_644507_0008 was served.

The licensee was specifically ordered to:
2. Provide education to all staff to ensure that staff area able to identify when residents are resistive to care and implement appropriate interventions.
The compliance date was October 31, 2017.

Inspector #110 interviewed the Executive Director (ED) who revealed there were 140 staff in the home at the time the order was written.

During an interview with PSW #109 they revealed to Inspector #110, that they had not received the above required training when asked. PSW #107 was vague on whether this specific training had been provided when also interviewed.

Interview with the DOC and Behavioural Support RPN (BS-RPN) identified that the Gentle Persuasive Approach (GPA) or recharge GPA were the education sessions by which the home was educating staff to identify when residents were resistive to care and the implementation of appropriate interventions.

Review of the education material provided, staff interviews including DOC and Executive Director and BS –RPN indicated that 15 staff had received training at the time of this

inspection. The education sessions were held November, 2017 and February 2018 both sessions were after the compliance date of October 31, 2017. Currently there were 129 out of 140 (92%) staff left to be trained, including PSW #109 and #107.

The licensee has failed to complete section #2 of CO #001 to provide education to all staff to ensure that staff area able to identify when residents are resistive to care and implement appropriate interventions. [s. 101. (3)] [s. 101. (3)]

2. A previous compliance order (#002) was served under O.Reg. 79/10, s.36 and issued August 2, 2017, during inspection #2017_644507_0008.

Order #002 under inspection #2017_644507_0008 directed the licensee to prepare, submit and implement a plan to achieve compliance in the area of safe transferring and positioning techniques when assisting residents with transfers using mechanical lifting devices.

The licensee was specifically ordered to:
2. Provide education to all direct care staff in mechanical lift transfers, and
3. Implement an auditing system to ensure staff adherence with safe lifting and transferring techniques when assisting residents.
The home was ordered to be in compliance by November 30, 2017.

Interviews were held by Inspector #116 with the DOC and staffing coordinator #127 that indicated the home had a complement of 68 personal support workers (six identified as temporary full time) and a complement of 41 registered staff members that would require hands on training on mechanical lift transfers.

Review of the home's education records held on lift training and safe lift ambulation indicated that 21 out of 68 (30.88%) personal support workers and 14 out of 41 (34%) registered staff members received the required education by the compliance date of November 30, 2017 as outlined in the original order.

It is noted that several in-services were held and conducted on lift and safe lift ambulation with a high participation rate over the period of December 2017.

Interviews with the DOC and staff #127 indicated that the lift training and safe lift ambulation were the education sessions used interchangeably by which the home was educating staff on the safe use of mechanical transfers and to be in compliance with the

outstanding order under s.36.

Interviews held with PSW staff members #107 and #126 stated they had previously received training on mechanical lifts however; they were unaware as to when they last attended.

Review of the materials provided and interviews held with the ADOC, DOC and clinical partner indicated that at the time of the issuance of the order the home utilized an auditing tool provided by ARJO which is the same auditing tool currently in use. Interviews held with the ADOC, DOC, clinical care partner and the Executive Director could not demonstrate or provide supporting information to validate the implementation of an auditing system in place which ensures staff adherence with safe lifting and transferring techniques when assisting residents.

The licensee has failed to complete section #2 and #3 of CO #002 to provide education to all direct care staff in mechanical lift transfers and to implement an auditing system to ensure staff adherence with safe lifting and transferring techniques when assisting residents [s. 101. (3)]. [s. 101. (3)]

***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 the licensee comply with every order made under this Act, to be implemented voluntarily.***

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**WN #2: 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 staff participated in the implementation of the infection prevention and control program.

During the initial walk through of the home an identified resident room (rm), a semi-private accommodation, was noted to have personal protective equipment (PPE) and an identified precaution sign attached to the door indicating that precautions were in place.

Upon enquiry with PSW staff member #102, who was assigned to the residents rm indicated being unaware of the identified precautions that were in place for the room and which resident the precautions were in place for. The inspector enquired whether communication is provided upon initiation of shift in regards to precautions of which PSW staff member #102 indicated they are not a regular staff member of the unit and was not informed prior to commencing the shift. PSW staff member #102 further indicated that they had provided personal care to both residents within the room during the shift. A discussion was also held with PSW staff #109 who indicated that staff members are to be aware of the identified precautions in place prior to providing care to affected residents.

On the same day, further enquiry was held with registered staff member #103 who initially conveyed being unaware of the identified precautions in place. Upon review, registered staff member #103, indicated that the precautions in place were for resident #011 and stated that the precaution was due to identified symptoms and the resident would be removed from isolation as of the proceeding evening shift as the precautions are no longer required.

On the following day, inspector #116 observed the identified precautions and PPEs were still in place by the identified room. The inspector enquired on the rationale for the PPEs and precautions with the registered staff member on the unit. As per registered staff member #104, the resident had a confirmed diagnosis of an identified chronic infection which required contact precautions and the usage of PPEs for all care aspects. Registered staff #104 indicated that PPEs should be donned upon entry to a room where the identified precautions are in place and removed prior to exiting the area.

An interview held with the DOC acknowledged the above mentioned observation and confirmed that the staff did not participate in the implementation of the infection prevention and control (IPAC) program in the home. [s. 229. (4)]

***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 participated in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #022 was identified in a complaint to exhibit responsive behaviours towards other residents in the home. The complaint identified that an identified intervention was to be in place and that this intervention was not implemented on an identified date.

Review of resident #022's clinical records identified a trend of responsive behaviours . A review of resident #022's written plan of care during the time frame in question, identified them with responsive behaviors and interventions including an identified intervention.

Interview with PSW #128 acknowledged that resident #022 had responsive behaviours , and that an identified intervention was to be in place according to their written plan of care. PSW #128 reported that the identified intervention was not always provided to resident #022 as required.

Interview with RN #117 acknowledged that resident #022 had responsive behaviours , and also revealed that an identified intervention was to be in place according to their written plan of care. RN #117 also reported that the identified intervention was not always provided to resident #022 as required.

Interview with the DOC and ADOC indicated that as of an identified date, resident #022 was to be provided the required intervention. The DOC reported that when the resident #022 had received the intervention, the information would be documented on the home's Daily Staffing Roster report.

Inspector #648 reviewed the home's Daily Staffing Roster report, and revealed the resident did not receive the required intervention on the date identified in the complaint. The DOC confirmed that resident #022 did not receive the identified intervention as specified in the resident's plan of care. [s. 6. (7)]

2. On an identified date, the MOHLTC received a complaint related to improper transfer methods of resident #018.

Review of the resident #018's written plan of care related to transferring requirements included direction to staff to on how to transfer resident #018.

Review of the home's policy entitled "Resident Transfer and Lift Procedures" (policyVII-G-20.20, revised December 2017) directed staff to lift/transfer resident and use transfer and repositioning aids according to the plan of care.

An interview held with PSW staff #126, who was assigned to resident #018 on the date identified in the complaint, confirmed resident #018 was not transferred according to the written plan of care. No injury was identified or reported as a result of the improper transfer.

Review of the home's internal investigation notes, progress notes for resident #018 and staff interviews were reviewed with the DOC. The DOC acknowledged that staff failed to ensure that the care set out in the plan of care in relation to transfers was provided to resident #018 as specified in the plan on or around the identified date. [s. 6. (7)]

3. A complaint was submitted to the Ministry of Health and Long Term Care indicating that on an identified date staff failed to follow resident #018's plan of care by failing to follow an intervention in the written plan of care.

Observations during the course of the inspection identified signage advising staff of the required interventions.

Interviews with frontline staff, including PSW #126, PSW #115, and RN #117 identified and acknowledged the intervention in place for resident #018.

Interview with PSW #126 reported that on the identified date, they had not followed the resident's plan of care as required.

An interview with the DOC confirmed resident #018's intervention and acknowledged that staff had not provided care to the resident as specified on the identified date in the complaint. [s. 6. (7)]

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**Issued on this 15th day of May, 2018**

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

**Original report signed by the inspector.**