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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 28, 2018	2018_594624_0013	015863-18, 015894-18, 016050-18, 016081-18, 018021-18	Complaint

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

BAIYE OROCK (624)

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): July 23, 24, 25, 27, 30 and 31, 2018. An offsite telephone interview was conducted on August 7, 2018.

The following complaint logs were inspected during this inspection:
Log #015863-18 and 015894-18 related to high temperatures in the home,
Log #016050-18 related to the care of residents,
Log #016081-18 related to an allegation of staff to resident abuse, and
Log #018021-18 related to an allegation of retaliation from the licensee

During the course of the inspection, the inspector(s) spoke with the Vice President of Operations (VPO) of the licensee, the Executive Director (ED), the Director of Care (DOC), the Acting ED, the Environmental Service Manager (ESM), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs) and the Scheduling Clerk.

A tour of the home was completed and observations were made of resident to resident interactions, staff to resident interactions during care provision, and thermostat readings on the different resident home areas.

A review was also completed of residents' health records, temperature logs of the different resident home homes, heating ventilation and air conditioning (HVAC) maintenance records, the licensee's internal investigation records, the licensee complaint logs, and staff schedules.

Relevant policies and procedures related to zero tolerance of abuse and neglect, whistleblowing protection, the management of complaints, skin and wound care, and hot weather management, were also reviewed by the Inspector.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

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)

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. (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 :

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Complaint log #016050-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date. As per the complainant, resident #003 was to have a specified intervention during every shift. The complainant indicated that on two identified dates, the said intervention was not provided as required.

A review of the health records of resident #003 was completed for the month of the year which included the two identified dates above. The review indicated that on both identified dates, resident #003 had an identified incident in the resident's home area, with no sustained injury.

According to documented records on the first identified date written by RN #106, the Physiotherapist, and by another registered nurse, resident #003 was noted by all three staff members to not have the specified intervention in place on that date. As per reviewed documented records related to second date, the reviewed records did not indicate whether or not the resident had the specified intervention present at the time of the identified incident

A review of the Physician order section of resident #003's chart indicated that about a week prior to the first identified date above, the resident was ordered to have the specified intervention in place. A review of a specified home record on the second identified date indicated that the specified intervention was not in place during which time resident #003 had an identified incident with no injury. This was confirmed by the Scheduling Clerk who provided the reviewed specified home record to the Inspector.

In separate interviews conducted by Inspector #624 with PSW #105, RN #106, and the

Director of Care (DOC), all three indicated that the expectation in the home is that care set out in a resident's plan of care should be provided to the resident as specified in the plan. In the same interview with RN #106, the RN confirmed that the specified intervention was not provided to resident #003 on the first identified date as had been documented by RN #106, the Physiotherapist and the other RN.

In the interview with the DOC, the DOC indicated that even though the specified intervention for resident #003 was not in place on both identified dates, the resident still received the care they needed. The DOC was however unable to provide clear explanation as to how care set out in the plan of care was provided to the resident as specified in the plan when the specified intervention was not provided as per the plan of care of resident #003 on both identified dates.

The licensee therefore failed to ensure that a specified intervention set out in the plan of care of resident #003, was provided to the resident as specified in the resident's plan.

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.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

Complaint log #016050-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date. As per the complainant, resident #003 was to have a specified intervention in place during every shift. The complainant indicated that on two identified dates, the specified intervention was not provided as required. In the same complaint, the complainant also indicated that on another identified date, resident #002 had an identified incident as a result of a planned specified intervention not provided to the resident.

According to email records provided by the complainant to Inspector #624, on a specified date and time, the complainant had sent an email to the Vice President of Operations (VPO) for the licensee about the concerns outline in the complaint above. A review of health records in the home and the MOHLTC records did not indicate that this written complaint about the care of resident #002 and resident #003 was forwarded immediately to the Director (i.e. MOHLTC).

In separate interviews with the VPO, the Director of Care (DOC), the Acting Executive Director, and the Executive Director (ED), all four managers indicated that any complaint that is submitted to the home in written format, email included, is considered a written complaint.

On whether the received email from the complainant was forwarded immediately to the MOHLTC on the date the complaint was received, the VPO indicated that when a written complaint is received, the first step is to contact the complainant and establish clarifications about the concerns. After obtaining the clarifications, a decision is then made whether to forward or not to forward the complaint to the MOHLTC. The VPO indicated that they were unable to tell whether this particular complaint was forwarded to MOHLTC as the procedure in place is that when they receive a written complaint at the Executive level, the complaint is forwarded to the home for proper management.

The DOC, the Acting ED and the ED were unable to tell whether or not this written complaint was forwarded to the Ministry on the day it was received. A review of the complaint logs in the home for the concerned month revealed no records in the home indicating that the written complaint was forwarded to the MOHLTC. Ministry fax numbers were provided to the licensee upon the inspector's exit from the home for any records on this complaint to be forwarded to the MOHLTC. At the time of compiling this report, nine days after exiting the home, no such records had been submitted to the MOHLTC specifically related to the written complaint in question.

The licensee therefore failed to ensure that a written complaint about the care of two residents was forwarded immediately to the MOHLTC.

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 every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1.The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Paragraph 3 (Ontario Regulation 79/10, section 101 (1) 3) states:
A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Related to the written complaint in WN #2, a review of email correspondence between the complainant and the VPO did not indicate a response was made to the complainant indicating what the licensee had done to resolve the concerns raised in the written complaint. A review of the licensee's complaint logs for the month in question did not indicate any records of a response ever made to the complainant related to what had been done to resolve the raised complaint.

In an interview with the VPO on an identified date, the VPO indicated that once a complaint is received by their office, the said complaint is forwarded to the Long-Term Care Home (LTCH), and that it is the LTCH that responds to the complainant after investigating the concern.

In separate interviews with the Director of Care (DOC), the Acting Executive Director (ED), as well as the ED, the DOC indicated they did not receive the said written complaint from the VPO but was aware of the concern. The DOC further indicated they could not speak to the details about the response made to the complainant as they did not make a response to the complainant. The acting ED indicated that they were aware of the concern raised by the complainant and are aware that the VPO was in contact with the complainant but indicated that they were not aware of the contents of any correspondence between the VPO and the complainant. The ED indicated that they did not personally send any response to the complainant related to the written complaint.

The licensee has therefore failed to ensure that when a written complaint about the care of resident #002 and #003 was received, that a response was made to the complainant within 10 business days indicating what the licensee had done to resolve the complaint, or if the licensee believed the complaint to be unfounded and the reasons for the belief.

2. The Licensee has failed to ensure that, related to any written complaint, a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant?

Related to the same complaint in WN#2, a review was completed by Inspector 624 of the licensee complaint log for the month the complaint was received. The review revealed that there was no documented record kept in the home outlining the nature of the complaint, the date the complaint was received, actions taken to resolve the complaint, if there was any final resolution, as well as any response made to the complainant.

In an interview with the VPO on an identified date, the VPO indicated that such records will be found in the home. In separate interviews with the DOC, the Acting ED, and the ED, all indicated that it is the licensee expectation that records are to be kept in the home outlining how every written complaint about the care of a resident has been handled. All three managers were unable to provide any records kept in the home related to the written complaint about the care of residents #002 and #003.

MOHLTC fax numbers were provided to the licensee upon the inspector's exit from the home for any records on this complaint to be forwarded to the MOHLTC. At the time of compiling this report, nine days after the inspector exited the home, no such records had been submitted to the MOHLTC specifically related to the written complaint in question.

Issued on this 4th day of September, 2018

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

Original report signed by the inspector.