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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 3, 2019	2019_486653_0012	026064-17, 000830-18, 015190-18, 001289-19	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

ROMELA VILLASPIR (653), JOVAIRIA AWAN (648)

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): April 26, 29, 30, May 1, 2, and 3, 2019.

During the course of the inspection, the following complaint intakes had been inspected:

Log #(s):
-015190-18 and 001289-19 related to skin care, plan of care, continence care and bowel management;
-026064-17 and 000830-18 related to nursing and personal support services and plan of care.

During the course of the inspection, the inspectors carried out observations of resident care provision, reviewed the home's staffing schedule, the home's investigation notes, complaints and Critical Incidents (CI) binder, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), External Care Provider (ECP), Registered Dietitian (RD), Physiotherapist (PT), Nurse Practitioner (NP), Director of Resident Programs and Admissions (DRPA), Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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

- **1 WN(s)**
- **1 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	Légende 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 :

1. The licensee had failed to ensure that care was provided to resident #002 as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) received two separate complaints related to resident #002's significant change in condition, and nutrition and hydration concerns.

A telephone interview with the complainant indicated resident #002 passed away due to a significant change in condition related to a medical condition. The complainant further indicated they were concerned about the care provided to the resident and questioned if the significant change could have been initially prevented.

A review of resident #002's written plan of care indicated they were to receive an identified care service from an External Care Provider (ECP) at an identified time.

A review of resident #002's progress notes revealed they had received the identified care service from the ECP on five different dates.

During an interview, the ECP indicated to the inspector they come to the home at an identified time to provide the care service to their clients, except when the home was on outbreak. They would document on PCC progress notes after they had provided the service to the residents. The ECP acknowledged they had provided the identified care service to resident #002. The inspector read the dates noted on PCC when the ECP provided the identified care service to resident #002, and asked them why the service was not provided at the specified time as per the resident's plan of care in two different time periods. The ECP indicated they remember the home had a long outbreak and water problem, which may have been the reason for the gaps.

A review of the letter correspondence between Associate Director of Care (ADOC) #107 and the York Region Public Health Inspector identified the home was on respiratory outbreak during an identified time period, but there was no documentation that the home was on outbreak around the time period the identified care service had not been provided to resident #002.

During an interview, the Director of Care (DOC) acknowledged that based on the above mentioned information presented by the inspector, the care service had not been provided to resident #002 at the specified time as per their plan of care, between an identified time period. [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 3rd day of June, 2019

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

Original report signed by the inspector.