Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Oct 21, 2019	2019_626501_0023	011546-19	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

SUSAN SEMEREDY (501)

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): October 10, 11, 16, 17, 18, 2019.

During this inspection the following intake was inspected:
Log #011546-19 related to the plan of care.

Inspector #760, Jack Shi, attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), nurse practitioner (NP), Director of Dietary Services (DDS), registered dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), and family members.

During the course of inspection, the inspectors(s) conducted observations of personal care, staff and resident interactions and snack passes. Inspector(s) also reviewed health records, home's complaint records, snack delivery reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) from a family member of resident #001 regarding the care being provided to the resident and unexplained altered skin integrity. An interview with this family member indicated they were also concerned about the resident receiving an identified nutritional supplement at snack time that was not of the appropriate fluid consistency.

According to the most recent plan of care, resident #001 had the potential for altered skin integrity as they tended to have identified movements. The resident was on an identified medication. Resident #001 was to have a protective device to prevent altered skin integrity. The resident's diet included a modified fluid consistency.

Inspectors #501 and #760 observed on an identified date, resident #001 was sitting in the hallway and did not have a protective device on an identified body area. An interview with registered nurse (RN) #101 indicated the device was sent to the laundry. Inspectors found the device under the sheets of resident #001's unmade bed. Interview with personal support worker (PSW) #102 indicated they were unfamiliar with working this shift, had not checked the resident's care plan and were therefore unaware that the resident was to have a protective device.

Inspectors #501 and #760 observed on another identified date, resident #001 was sitting in the hallway and did not have a protective device on an identified body area. Inspectors noted that there were two devices in the resident's room. An interview with PSW #112 indicated they thought the device was only for the night time.

An interview with Director of Care (DOC) #100 confirmed the staff should have placed the protective device on resident #001 on both above-mentioned days.

Inspectors #501 and #760 observed on an identified date, resident #001 was given an identified nutritional supplement by PSW #106. Inspector #501 asked the PSW if they thought this was of an appropriate fluid consistency and the PSW said they did not think so. A further interview with PSW #106 indicated they were unaware they needed to modify the consistency as they thought this was done by the dietary department.

Inspector #760 observed on an identified date, resident #001 was given a nutritional supplement by PSW #112 and did not modify the fluid consistency. An interview with PSW #112 indicated they did not think the milkshake was of the appropriate consistency but was not aware they were supposed to modify it.

An interview with Director of Dietary Services (DDS) #108 confirmed resident #001 should have received a nutritional supplement of an identified fluid consistency that was modified by the PSWs at point of service on both above-mentioned days.

The home failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan of care as they were not provided a protective device to prevent altered skin integrity and a nutritional supplement of an appropriate consistency at snack time. [s. 6. (7)]

2. Noncompliance was found related to resident #001 not receiving the care set out for the plan of care for altered skin integrity and a nutritional supplement that was not of an appropriate fluid consistency at snack time. Therefore, an increase in sample size was conducted which included resident #003.

Review of resident #003's most recent plan of care indicated the resident had altered skin integrity and had a protective device applied to an identified body area. As well, resident #003 was to receive a nutritional supplement of an identified modified fluid consistency at certain snack times.

Inspector #501 observed on an identified date, resident #003 was given a nutritional supplement that was not of the appropriate fluid consistency by PSW #110 at snack time. According to the PSW, nutritional supplements are modified by the dietary department.

An interview with DDS #108 indicated that identified nutritional supplements on snack carts are to be modified by PSWs at the point of service. DDS #118 confirmed that the care set out in the plan of care was not provided to resident #003 as specified in the plan of care as they did not receive an identified nutritional supplement that was of an identified fluid consistency.
[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 of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each snack.

A family member of resident #001 complained to Inspector #501 that the resident did not receive a nutritional supplement that was of the appropriate fluid consistency at snack time. Observations at snack times were conducted by Inspectors #501 and #760 for residents #001, #002, #003.

Inspectors #501 and #760 observed PSW #102 serving snack on an identified date and time. Resident #001 was observed sleeping in their assistive device in the hallway. PSW #102 did not offer resident #001 any snack and did not try to awaken them. An interview with PSW #102 indicated they did not usually work this shift and was told not to wake the residents up. An interview with registered dietitian (RD) #109 indicated that resident #001 was at nutritional risk and receives an identified nutritional supplement at snack times. The RD indicated that the expectation is for PSWs to attempt to gently awaken residents to receive their snack especially those at nutritional risk.

Inspectors #501 and #760 observed PSW #106 feeding resident #001 a nutritional supplement on an identified date and time. The resident consumed all the supplement and the PSW did not offer the resident any other beverage or snack. According to the snack delivery report, resident #001 was to be offered three other identified items. An interview with PSW #106 indicated they forgot to offer resident #001 these other items. An interview with RD #109 indicated residents should be offered all menu items available at each snack.

Inspector #501 observed PSW #110 feeding resident #003 a nutritional supplement on an identified date and time. The PSW did not offer the resident any other snack or beverage. According to the snack delivery report resident #003 was to be offered three other identified items. PSW #110 stated they had then completed their snack pass and when questioned why they did not offer other snacks to resident #003, they indicated that one of these items was not available as they had run out.

An interview with DDS #108 confirmed that planned menu items were not offered and available at each of the above-mentioned snack times for resident #001 and #003.
[s. 71. (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 that the planned menu items are offered and available at each snack, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The home has failed to ensure that drugs were stored in a medication cart that was locked.

Inspector #501 and #760 observed on an identified date and time that a medication cart in the hallway was unlocked, there were no staff members in sight and there were residents sitting to the side of the cart. Inspector #501 was able to open all drawers of this cart giving access to all drugs. The bottom drawer which contained a lockable bin was also found to be unlocked and contained narcotics. Inspector #501 looked around for a registered staff member and upon entering a nursing station across the hall found registered practical nurse (RPN) #104. The RPN came to the cart and immediately pushed down on the narcotics bin which rendered it locked. The RPN stated they had just given an identified narcotic to a resident and the computer on the cart was not working so they had to go to the nursing station. The RPN stated they should not have left the cart unattended.

An interview with DOC #100 confirmed that drugs stored in medication carts should be kept locked. [s. 129. (1) (a) (ii)]

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 drugs are stored in a medication cart that is locked, to be implemented voluntarily.

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.