Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 19, 2021	2021_823653_0009	020024-20, 022303-20, 022305-20, 023026-20, 025914-20, 000108-21, 002621-21, 003409-21, 005348-21	Critical Incident System

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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

ROMELA VILLASPIR (653), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 12, 13, 14, 15, 16, 19, 20, 21, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

-Log #(s): 020024-20, 025914-20, and 000108-21, were related to falls prevention and management;

-Log #(s): 023026-20, 003409-21, and 005348-21, were related to injuries from unknown cause;

-Log #022303-20, Compliance Order (CO) #001 issued on October 23, 2020, within report #2020_669642_0015, related to the LTCHA, 2007, s. 6 (10);
-Log #022305-20, CO #002 issued on October 23, 2020, within report #2020_669642_0016, related to the O. Reg. 79/10, s. 129 (1);
-Log #002621-21, CO #001 issued on February 12, 2021, within report #2021_823653_0005, related to the O. Reg. 79/10, s. 229 (4).

NOTE: A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to LTCHA, 2007, s. 6 (6), s. 6 (11) (b), and O. Reg. 79/10, s. 30 (2), were identified in concurrent inspection #2021_823653_0010 (Logs #020446-20, #020783-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), RAI Coordinator, Scheduling Coordinator, Resident and Family Experience Coordinator, Physiotherapist (PT), Associate Directors of Care (ADOCs), and the Director of Care (DOC).

During the course of the inspection, the inspectors toured the home, observed Infection Prevention and Control (IPAC) practices, drug storage, provision of care, staff to resident interactions, reviewed clinical health records, staffing schedule, staff education and training records, and relevant policies and procedures.

Inspector #746 was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **2 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
O.Reg 79/10 s. 129. (1)	CO #002	2020_669642_0016	535
O.Reg 79/10 s. 229. (4)	CO #001	2021_823653_0005	653
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2020_669642_0015	535

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 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 the staff used safe transferring techniques when assisting residents #011 and #013.

The home submitted a Critical Incident Report (CIR) for improper/ incompetent treatment of a resident that resulted in harm or risk to the resident. The CIR indicated that resident #011 had a fall during a transfer from their personal assistive device to the bed, sustained an injury, and was transferred to hospital. Separate interviews with Personal Support Workers (PSWs) #108 and #109 indicated they used a different sling size to transfer the resident at the time of the incident. An interview with the Physiotherapist (PT) indicated that the risk associated to not using the appropriate sling size during a transfer would be the uneven distribution of forces, which would alter the total transfer mechanics. An interview with Registered Practical Nurse (RPN) #110 indicated that after the resident fell out of the sling, the staff should have safely lowered the resident down to the floor and waited for the RPN to assess the resident, before placing them on the bed.

During an interview, Associate Director of Care (ADOC) #103 acknowledged that there was actual harm to resident #011 as a result of the transfer.

Sources: Review of CIR and resident #011's hospital discharge summary; Interviews with PSWs #108, #109, PT, RPN #110, and ADOC #103. [s. 36.]

2. During an observation, PSWs #107 and #117 transferred resident #013 from bed to their personal assistive deivce using a sling and the lift machine. An interview with PSW #117 indicated they normally used a different sling size for the resident's transfers, however, it was not available on the unit at the time. An interview with ADOC #103 indicated that the PSW should have asked the nurse to get the correct size sling for the transfer.

Sources: Inspector #653's observation; Interviews with PSW #117, and ADOC #103. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was free from neglect by staff in the home.

The home submitted a CIR regarding a fall with injury. On a day in December 2020, the resident had an unwitnessed fall, and they complained of pain four days later. Subsequently, the physician ordered a diagnostic imaging test, and pain intervention. The resident waited six days for the test to be completed, and the result was dictated, transcribed, and faxed to the home on the same day.

RPN #106 stated they found the test result which showed the injuries, five days after it was faxed to the home. They called and reported the results to the physician, and the resident was transferred to hospital, where the diagnosis of the injuries were verified, and treatment and interventions were implemented.

RPN #106 stated that the registered staff do not have a routine or protocol for picking up test results from the fax machine which was located downstairs on the main floor. They were unsure if the delay to the diagnostic imaging test completion was related to the holidays, and unsure why the test result was not communicated to the physician at the time it was dictated, transcribed, and faxed to the home. ADOC #103 stated that the expectation was for the portable diagnostic imaging test to be completed within two to three days, and verified that the result should have been communicated immediately upon receipt.

Sources: Review of CIR, and resident #004's clinical health records; Interviews with RPN #106, ADOC #103, and other staff. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provided direct care to residents #012, #013, and #011, as it related to their transfer sling size.

A review of resident #012's care plan did not identify the sling size to be used by staff for transfers. During an observation, PSWs #107 and #117 transferred the resident from their personal assistive device to the bed using a lift and a sling. During an interview, PSW #117 indicated to the inspector that they normally used a different sling size for the resident's transfers, however, it was not available on the unit at the time.

Sources: Review of resident #012's care plan; Inspector #653's observation; Interviews with PSW #117, and ADOC #103. [s. 6. (1) (c)]

2. A review of resident #013’s care plan did not identify the sling size to be used by the staff with transfers. During an observation, PSWs #107 and #117 transferred the resident from their personal assistive device to the bed using a lift and a sling. During an interview, PSW #117 indicated to the inspector that they normally used a different sling size for the resident’s transfers, however, it was not available on the unit at the time.

Sources: Review of resident #013’s care plan; Inspector #653’s observation; Interviews with PSW #117, and ADOC #103. [s. 6. (1) (c)]

3. A review of resident #011's care plan did not identify the sling size to be used by staff with transfers. Separate interviews with PSWs #108 and #109 indicated they usually used an identified sling size to transfer the resident, while RPN #110 indicated otherwise.

During an interview, RPN #118 stated that the staff did not normally see the transfer sling sizes on the care plan. When asked by the inspector how the staff would know the appropriate sling size to use for resident transfers, the RPN stated it was determined by the ADOC. An interview with ADOC #103 further acknowledged that the written plan of care of the residents did not provide clear directions to staff in regards to the appropriate sling size, and stated it should be indicated for staff to be aware of.

Sources: Resident #011’s care plan; Interviews with PSWs #108, #109, RPNs #110, #118, and ADOC #103. [s. 6. (1) (c)]

4. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborated with each other in the assessment of resident #003 so that their assessments were integrated, consistent with, and complemented each other.

The home submitted a CIR regarding a fall with injury. On a day in December 2020, resident #003 was found sitting on the floor with their back against the wall. They were last seen lying in bed prior to the unwitnessed fall. The resident was assessed by the registered staff and found to have no injury and a Head Injury Routine (HIR) was initiated. About seven hours after the fall, RPN #124 documented a change in the resident's HIR status. ADOC #103 verified that the home does have 24/7 physician coverage, however the RPN did not contact the Registered Nurse (RN) to further assess the resident, and the home's on-call physician was not notified of the resident's change in clinical condition. The lack of collaboration in their assessments placed the resident at risk for deterioration of their health status.

Sources: Review of CIR, and resident #003's clinical health records; Interviews with ADOC #103 and other staff. [s. 6. (4) (a)]

5. The licensee has failed to ensure that when resident #008 was admitted to the home, the resident was assessed, and an initial plan of care was developed based on that assessment.

A review of resident #008's clinical health records revealed they were assessed as at risk for falls upon admission. A review of their clinical health records revealed they had two falls on the day of their admission. The resident did not sustain any injuries from the first fall, however, they sustained injuries from the second fall. A review of resident #008's care plan with the RAI Co-ordinator and a separate interview with ADOC #102 revealed that the falls interventions were only added after the second fall.

Sources: Review of resident #008's clinical health records; Interviews with RAI Co-ordinator, ADOC #102, and other staff. [s. 6. (6)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #011 as specified in the plan, as it related to the appropriate sling size.

A review of resident #011's care plan indicated that they used an identified sling size for transfers. During an observation, the inspector noted that the resident had a different sling size underneath them. An interview with PSW #122 indicated they had to use a different sling size during the resident's transfer, as the required sling was not sent back

from the laundry. During an interview, ADOC #103 acknowledged that the staff did not provide care as specified in the plan when they used the a different sling size for resident #011's transfer.

Sources: Review of resident #011's care plan; Inspector #653's observation; Interviews with PSW #122, and ADOC #103. [s. 6. (7)]

7. The licensee has failed to ensure that different approaches had been considered in the revision of resident #004 and #001’s plan of care, when they were reassessed and their plan of care were revised because care set out in the plan had not been effective.

The home submitted a CIR, regarding a fall with injury. Resident #004 experienced multiple unwitnessed falls in the home, and on a day in December 2020, the resident had another unwitnessed fall, and sustained injuries.

ADOC #103 acknowledged that the resident’s care plan included interventions, however, since the resident continued to fall, the plan of care was not effective and different approaches should have been considered to prevent subsequent falls.

Sources: Review of CIR, progress notes; Interviews with ADOC #103, and other staff. [s. 6. (11) (b)]

8. The MLTC received an anonymous complaint related to resident #001's care.

A review of resident #001's clinical health records indicated that resident #001 had frequent unwitnessed falls, and on a day in October 2020, the resident had another unwitnessed fall. RPN #106 assessed the resident and noted an injury, and transferred them to hospital.

An interview with RPN #106 stated that although the resident had multiple falls prevention strategies already in place, those strategies were not working to prevent their falls, therefore new and different approaches were required to maintain the resident’s safety and prevent future falls.

Sources: Review of clinical health records; Interviews with RPN #106, PT, and other staff. [s. 6. (11) (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:
-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;
-the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
-when a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44;
-the care set out in the plan of care is provided to the resident as specified in the plan;
-when a resident is reassessed and if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care;, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident’s responses to interventions were documented.

A review of resident #008’s clinical health records revealed they had an unwitnessed fall outside of their room. A review of the resident’s physical chart and an interview with the Director of Care (DOC) revealed that a HIR assessment was not initiated for the unwitnessed fall as required by the home’s falls prevention and management program.

Sources: Review of resident #008’s care plan, and other clinical health records; Interviews with ADOC #102, and other staff. [s. 30. (2)]

2. The home submitted a CIR regarding a fall with injury.

On a day in December 2020, the staff found resident #003 sitting on the floor with their back against the wall. They were last seen lying in bed prior to the unwitnessed fall. The resident was assessed by the registered staff and found to have no injury, and HIR was initiated. After documentation of the initial two-hour clinical assessment, the HIR document was left blank for the next three one-hour time slots. About seven hours after the fall, RPN #124 documented a change in the resident’s HIR status. ADOC #103 verified that the HIR document should have been completed for each time-slot and the resident's responses should have been documented to ensure a proper clinical assessment and monitoring.

Sources: Review of CIR, and other clinical health records; Interviews with ADOC #103 and other staff. [s. 30. (2)]

3. The home submitted a CIR regarding a fall with injury. On a day in December 2020, resident #004 had an unwitnessed fall. The HIR documentation was incomplete for the time-slots, and at specified times, the word sleeping was written in the monitoring column. ADOC #103 verified that a clinical assessment and HIR documentation should have been completed for all time-slots for a period of 72 hours to ensure appropriate clinical monitoring of the resident.

Sources: Review of CIR, and other clinical health records; Interviews with ADOC #103, and other staff. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #010 has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #010's progress notes revealed they had an unwitnessed fall on a day in February 2021. A review of the resident's clinical health records revealed that a post-fall assessment had not been conducted using a clinically appropriate assessment instrument that was specifically designed for falls. During an interview, ADOC #102 indicated that the registered staff should have conducted the post fall assessment of resident #010, and that the risk associated to not completing a post fall assessment was not being aware of a potential injury. The ADOC further stated that the importance of a post fall assessment was to understand the circumstances of the fall, how the staff can prevent it from happening again, and to have the information to share with the physician, PT, and the family.

Sources: Review of resident #010's clinical health records; Interviews with ADOC #102, and other staff. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: 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 has failed to ensure that the Mechanical Lifting and Sling Safety Protocol policy was complied with.

According to O. Reg. 79/10, s. 58, Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

A review of the home's policy titled "Mechanical Lifting and Sling Safety Protocol", indicated that the nurse will assess the level of transfer and mobility at the time of move in and with any change in condition using the electronic lift and transfer assessment. A review of resident #011's electronic lift and transfer assessment at the time of move in, indicated they were to use an identified lift for transfers. A review of the PT's progress note two months later, and an interview with the PT indicated they received a referral for resident #011's transfer assessment and when they conducted the reassessment, they recommended a different lift for all transfers due to the resident's behaviours. The PT confirmed that they did not complete the electronic lift and transfer assessment as it was the nurse's responsibility, and the PT only provided recommendations. During an interview, ADOC #103 acknowledged that the home's policy was not complied with when an electronic lift and transfer assessment was not completed by the nurse when there was a change in resident #011's condition.

Sources: Review of the Mechanical Lifting and Sling Safety Protocol policy, and resident #011's clinical health records; Interviews with the PT, and ADOC #103. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #013's personal assistive device was cleaned and disinfected using at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there were none, with prevailing practices.

During an observation of resident #013's transfer from bed to their personal assistive device, Inspector #653 and PSW #107 noted a strong odour coming from the resident's personal assistive device. PSW #107 then took the 3M Cavilon Spray No Cleanse Skin Cleanser and sprayed it on the personal assistive device, and wiped it dry using the small white towel.

A review of the unit's PSW cleaning schedule for April 2021, revealed that resident #013's personal assistive device was scheduled to be cleaned on two identified dates, however, there were no staff initials to indicate that the cleaning was completed. Separate interviews with PSWs #120 and #117 who worked on the two identified dates, revealed that they did not clean resident #013's personal assistive device as scheduled. During an interview, the DOC acknowledged that resident #013's personal assistive device were to be cleaned and disinfected using the Vert2GO Saber low-level disinfectant solution.

Sources: Inspector #653's observation; Review of the staffing schedule and PSW cleaning schedule; Interviews with PSWs #120, #117, and the DOC. [s. 87. (2) (b)]

WN #8: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of the incident that caused an injury to resident #010 that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The home submitted a CIR for an injury that was not related to a fall. The CIR indicated that on a day in February 2021, resident #010 complained of pain during care provision. A review of the resident’s physical chart revealed that on the same day, the physician ordered a diagnostic imaging test to rule out injuries. On the next day, the result came back and an injury was confirmed, and the resident was sent to hospital as per the Nurse Practitioner (NP)'s order. During an interview, the DOC acknowledged that the home failed to inform the Director no later than one business day after the occurrence of the incident as the CIR was submitted two days after the resident was sent to hospital with a confirmed injury.

Sources: Review of CIR, and the resident’s physical chart; Interviews with the DOC, and other staff. [s. 107. (3)]

Issued on this 21st day of May, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653), VERON ASH (535)
Inspection No. / No de l’inspection :	2021_823653_0009
Log No. / No de registre :	020024-20, 022303-20, 022305-20, 023026-20, 025914-20, 000108-21, 002621-21, 003409-21, 005348-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 19, 2021
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
LTC Home / Foyer de SLD :	Bradford Valley Care Community 2656 6th Line, Bradford, ON, L3Z-2A1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cathy VanBeek

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with s. 36 of the Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

1. Review the following with Personal Support Workers (PSWs) #108, #109, #107, and #117:
-Grounds of Compliance Order (CO) #001;
-Appropriate transfer sling size for residents #011 and #013, as per the manufacturer's sling sizing guide.

2. Document the review, including the date, attendees, and the staff member who facilitated the review.

3. A record is required to be kept by the licensee for all actions undertaken in items #1 to #2.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff used safe transferring techniques when assisting residents #011 and #013.

The home submitted a Critical Incident Report (CIR) for improper/ incompetent treatment of a resident that resulted in harm or risk to the resident. The CIR indicated that resident #011 had a fall during a transfer from their personal assistive device to the bed, sustained an injury, and was transferred to hospital. Separate interviews with Personal Support Workers (PSWs) #108 and #109 indicated they used a different sling size to transfer the resident at the time of

the incident. An interview with the Physiotherapist (PT) indicated that the risk associated to not using the appropriate sling size during a transfer would be the uneven distribution of forces, which would alter the total transfer mechanics. An interview with Registered Practical Nurse (RPN) #110 indicated that after the resident fell out of the sling, the staff should have safely lowered the resident down to the floor and waited for the RPN to assess the resident, before placing them on the bed.

During an interview, Associate Director of Care (ADOC) #103 acknowledged that there was actual harm to resident #011 as a result of the transfer.

Sources: Review of CIR and resident #011's hospital discharge summary; Interviews with PSWs #108, #109, PT, RPN #110, and ADOC #103. (653)

2. During an observation, PSWs #107 and #117 transferred resident #013 from bed to their personal assistive deivce using a sling and the lift machine. An interview with PSW #117 indicated they normally used a different sling size for the resident's transfers, however, it was not available on the unit at the time. An interview with ADOC #103 indicated that the PSW should have asked the nurse to get the correct size sling for the transfer.

Sources: Inspector #653's observation; Interviews with PSW #117, and ADOC #103.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #011 as they sustained an injury, and minimal risk of harm to resident #013, as a result of the unsafe transfer.

Scope: The scope of this non-compliance was a pattern, as the unsafe transfers were carried out by the PSWs for two of the three residents reviewed during the inspection.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

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Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jun 30, 2021

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must prepare, submit, and implement a plan to ensure that residents are not neglected. The plan must include:

1. Measures for timely receipt of diagnostic results.

2. Steps to ensure that the staff follow best practice for following through on physicians' orders for diagnostic testing.

3. An auditing schedule to ensure the new process is followed.

4. A record is required to be kept by the licensee for all actions undertaken in items #1 to #3.

Please submit the written plan for achieving compliance for inspection #2021_823653_0009 to Romela Villaspir, LTC Homes Inspector, MLTC, by June 7, 2021.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/ Personal Health Information (PHI).

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004 was free from neglect by staff in the home.

The home submitted a CIR regarding a fall with injury. On a day in December 2020, the resident had an unwitnessed fall, and they complained of pain four days later. Subsequently, the physician ordered a diagnostic imaging test, and pain intervention. The resident waited six days for the test to be completed, and the result was dictated, transcribed, and faxed to the home on the same day.

RPN #106 stated they found the test result which showed the injuries, five days after it was faxed to the home. They called and reported the results to the physician, and the resident was transferred to hospital, where the diagnosis of the injuries were verified, and treatment and interventions were implemented.

RPN #106 stated that the registered staff do not have a routine or protocol for picking up test results from the fax machine which was located downstairs on the main floor. They were unsure if the delay to the diagnostic imaging test completion was related to the holidays, and unsure why the test result was not communicated to the physician at the time it was dictated, transcribed, and faxed to the home. ADOC #103 stated that the expectation was for the portable diagnostic imaging test to be completed within two to three days, and verified that the result should have been communicated immediately upon receipt.

Sources: Review of CIR, and resident #004's clinical health records; Interviews with RPN #106, ADOC #103, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #004 since they were diagnosed with injuries, and had a significant change in health status.

Scope: This was an isolated case as no other incidents of neglect were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 19 (1) of the LTCHA, and three Written Notifications (WNs), two Voluntary Plan of Corrections (VPCs), and one CO that was complied on February 11, 2021, were issued to the home. (535)

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Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 19, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office