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
Dec 14, 2021	2021_918426_0006	008159-21, 011933-21, 012087-21, 012910-21, 014568-21, 015497-21, 017403-21	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

FRANK GONG (694426)

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): November 25, 26, 29, 30, December 1, 2, 3, 6, 7, 8, 9, 2021

The following intakes were completed during this Inspection:
Log #008159-21 related to conducting a follow up to Compliance Order #002 issued to the licensee during inspection #2021_823653_0009 on May 19, 2021, with a compliance due date of July 19, 2021, regarding the prevention of abuse and neglect.
Log #012087-21 related to the prevention of abuse and neglect.
Log #012910-21 related to the prevention of abuse and neglect.
Log #011933-21 related to resident fall with transfer to hospital and significant change in health condition.
Log #014568-21 related to resident fall with transfer to hospital and significant change in health condition.
Log #015497-21 related to resident fall with transfer to hospital and significant change in health condition.

A Complaint inspection (#2021_941746_0007) was conducted concurrently to this Critical Incident System Inspection.

During the course of the inspection, the inspector(s) spoke with Associate Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Director of Environmental, Behavioural Supports Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, and residents.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, reviewed clinical health records, internal investigation notes, staff schedules, and discussed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 #002	2021_823653_0009	694426

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #004's right to be protected from abuse.

Resident #003 had documented specified responsive behaviours. Resident #004 had documented specified responsive behaviours.

On a specified date, resident #004 was found with specified injuries. A review of the home’s investigation indicated that resident #004 had sustained specified injuries due to resident #003.

After discussion with registered staff #114, it was noted that resident #004 had a history of specified responsive behaviours. Registered staff #114 indicated that when the incident was discussed with resident #004, they verified that resident #003 had caused the specified incident with injury. Resident #004 further implied specified interactions with resident #003 immediately prior to the incident. ADOC #101 verified that physical abuse was substantiated by the home.

Failure to ensure the resident's right to be protected from abuse may result in physical and emotional injuries.

Sources:
Related Critical Incident Report, the home’s investigation notes, resident #003 and #004’s plan of care and progress notes, interviews with RPN #125, registered staff #114, and ADOC #101 [s. 3. (1) 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 every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #2: 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 staff used safe transferring techniques when assisting resident #001.

Resident #001 required a specified transfer device for transfers. A critical incident was submitted by the home following the discovery of specified injuries on resident #001.

PSW #106, #126, and RPN #113 indicated that they discovered and reported the injuries on resident #001 on a specified date, they further noted that the resident did not exhibit any signs of injury on the day prior. PSW #126 indicated that the resident had received specified care on a specified date.

PSW #112 confirmed that they provided the resident with specified care on the specified date; no injuries were noted to the resident during that time. PSW #112 indicated that during the evening, the resident was transferred improperly with one staff member instead of two. PSW #112 denied causing any injuries to the resident during the transfers.

ADOC #101 verified that there must be at least two staff present to operate the specified transfer device, and failure to do so may result in risk of injuries to the resident.

Sources:
Related Critical Incident Report, the home’s investigation notes, Zero Lift & Protocol Policy, resident #001’s plan of care, Documentation Survey Report v2, and progress notes, interviews with PSW#106, #112, #126, RPN #113, and ADOC #101 [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #006 after they have fallen.

Resident #006 had a specified number of falls on a specified date, that resulted in transfer to hospital and specified injuries.

Following the resident’s fall on specified date, registered staff #116 indicated that they had manually lifted the resident without the aid of a transfer device.

ADOC #101 verified that manually lifting a resident was not in compliance with the Zero Lift & Protocol Policy set out by the home, and may result in risk of injury to both the

resident and staff.

Failure to ensure that staff used safe transferring techniques when assisting residents may result in risk of physical injury to both the resident and staff.

Sources:
Related Critical Incident Report, observations, Zero Lift & Protocol Policy, resident #006's plan of care, assessments, MDS, and progress notes, interviews with registered staff #116 and ADOC #101 [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 #006 fell, post-fall assessments were completed using a clinically appropriate assessment instrument designed specially for falls.

Resident #006 had a specified number of falls on a specified date, that resulted in transfer to hospital and specified injuries.

When resident #006 fell, appropriate post-fall assessment instruments were not completed. RPN #123 and registered staff #116 indicated that they responded to the incidents and confirmed that they did not immediately document the post-fall assessments through a clinically appropriate tool.

On a specified date, post-fall assessment documentations were completed by RPN #115, who indicated that they were not present at the time of the incident.

ADOC #101 verified that the registered nursing staff responding to the incident should have completed the post fall assessments immediately following a resident's fall.

Failure to ensure that when a resident has fallen, post-fall assessments were completed using a clinically appropriate assessment instrument, may result in a delay in receiving treatment and further injury.

Sources:
Related Critical Incident Report, observations, Falls Prevention and Management Policy, resident #006's plan of care, assessments, MDS, and progress notes, interviews with RPN #123, #115, registered staff #116 and ADOC #101 [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, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: 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.

PSW #107 and RN #105 were observed exiting resident rooms while wearing their face mask improperly. Staff acknowledged that they were aware of the IPAC requirements. IPAC Lead verified that the staff did not wear their face masks according to IPAC requirements.

PSW #104 was observed exiting a resident room with specified additional precautions without performing hand hygiene. Staff acknowledged that they were aware of the IPAC requirements.

A visitor was observed exiting a resident room with specified additional precautions without performing hand hygiene, and observed entering another resident room. A discussion with PSW #106 indicated that it was the staff's responsibility to provide education. IPAC Lead verified that all persons should be performing hand hygiene upon exiting resident rooms, and failure to do so may result in transmission of disease.

Failure to ensure that staff participated in the implementation of the infection prevention and control program may increase the risk and transmission of infectious disease.

Sources: Observations and interview with IPAC Lead. [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 all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 20th day of December, 2021

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

Original report signed by the inspector.