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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 31, 2013	2013_168202_0064	T-24-13	Complaint

Licensee/Titulaire de permis

SPECIALTY CARE - BRADFORD INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

Long-Term Care Home/Foyer de soins de longue durée

BRADFORD VALLEY
2656 6th Line, Bradford, ON, L3Z-3H5

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

VALERIE JOHNSTON (202)

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): November 27, 28, 29, and December 02, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Environmental Services, Assistant Director of Care, Registered Nursing Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed home's hot water temperature records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius. [s.90 (2)(i)]
On November 28, 2013, during the course of this inspection hot water temperatures serving bathtubs and showers used by residents were taken at 10:50 hours which revealed the following:
Heritage Home Area:
Bathtub: 34.0'C
Shower: 37.5'C
Lake Home Area:
Bathtub: 37.8'C
Cottage Home Area:
Bathtub: 33.8'C
Orchard Home Area:
Bathtub: 36.9
Direct care staff interviews revealed that the hot water serving all bathtubs and showers used by residents is usually lukewarm. Staff indicated that when showering or bathing residents they often have to let the water run for over five minutes and even after doing so the water is still cool. Staff confirmed that they will refer to the water temperature gauge on the bathtub which generally reads between 27'C and 34'C or use their wrist to determine of the temperature is appropriate for the resident. An interview with the Director of Environmental Services (DES) confirmed the above temperatures and indicated that the low temperatures of hot water serving the bathtubs and showers used by residents may be as a result of cartridges requiring

replacement. [s. 90. (2) (i)]

2. The licensee failed to ensure that procedures are developed and implemented to ensure that if the home is not using a computerized system to monitor the water temperatures, the water temperature is monitored once per shift in random locations where residents have access to hot water. [s.90. (2)(k)]
On November 28, 2013 during the course of this inspection the temperature of hot water serving random bathtubs and showers used by residents were taken at 10:50 hours which revealed:
Heritage Home Area:
Bathtub: 34.0'C
Shower: 37.5'C
Lake Home Area:
Bathtub: 37.8'C
Cottage Home Area:
Bathtub: 33.8'C
Orchard Home Area:
Bathtub: 36.9
An interview with the Director of Environmental Services (DES) revealed that the home has a computerized system to monitor the water temperatures at the source, however the computerized system does not monitor water temperatures throughout the building where residents have access to hot water. The DES indicated that Registered Nursing staff are directed to record hot water temperatures manually once per shift in random locations where residents have access to hot water on a water temperature recording sheet. The water temperature recording sheet is reviewed monthly and the DES is to be alerted when temperatures are below 40'C or above 49'C. The DES confirmed in an interview that bathtub and shower temperatures are not included as part of the random locations that are monitored by registered staff. A review of the recorded water temperatures for November 01, 2013-November 28, 2013 revealed that no temperatures were taken and recorded on the following dates and confirmed by the DES:
-November 03, evening shift
-November 05, evening shift
-November 12, day and evening shift
-November 13, day and evening shift
-November 14, day shift
-November 15, evening and night shift
-November 16, evening and night shift

-November 22, day, evening and night shift
-November 24, night shift
-November 26, evening and night shift
-November 27, evening and night shift
-November 28, day and evening shift [s. 90. (2) (k)]

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 procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius and if the home is not using a computerized system to monitor the water temperatures, the water temperature is monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every plan of care is based on an interdisciplinary assessment of each resident's sleep patterns and preferences. [s. 26 (3) 21]

A review of resident #003's written plan of care directs staff to document resident #003's quality of sleep, however does not include resident #003's sleep patterns and preferences. An interview with an identified Registered Practical Nurse confirmed that resident #003's plan of care does not include an interdisciplinary assessment of his/her sleep patterns and preferences. [s. 26. (3) 21.]

Issued on this 31st day of December, 2013

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