



**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**

**Division de la responsabilisation et de la
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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
Sep 19, 2013	2013_109153_0020	T-341-13, T- 370-13	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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 16, 19, 20, 21, 2013.

During the course of the inspection, the inspector(s) spoke with Director of Clinical Services(DOC), Associate Director of Care(ADOC), Physician, Pharmacist, Physiotherapist, Registered Nurse(RN), Restorative Care Aide, Personal Support Workers(PSWs)and Substitute Decision Maker(SDM).

During the course of the inspection, the inspector(s) reviewed clinical health records, staff training records, home policies related to medication administration, medication incident report, consent to treatment, duty to report and whistle blower protection.

Completed observations of staff to resident interactions, staff assisted transfers and medication administration.

The following Inspection Protocols were used during this inspection:
Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee did not ensure that every resident has the right to give or refuse consent to any treatment for which the resident's consent is required by law and to be informed of the consequences of giving or refusing consent.

A physician order was received for an identified medication for Resident #1. Resident #1 was administered the prescribed medication without the consent of the substitute decision maker.

A review of the physician order sheet revealed the box titled POA notified had not been completed.

A review of the progress notes revealed that a registered staff member had contacted the substitute decision maker to apologize for not informing her of the new medication prescribed by the physician 2 weeks earlier in order to receive consent for the treatment.

A review of the home's policy titled "Consent to Treatment" VI-10.10 revealed that staff are to obtain consent for any new treatment from the substitute decision maker for residents who are not capable of giving or refusing consent.

When interviewed the DOC confirmed the registered staff are to notify the Power of Attorney for Personal Care prior to administering new administration. [s. 3. (1) 11. 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 every resident has the right to give or refuse consent to any treatment for which the resident's consent is required by law and to be informed of the consequences of giving or refusing consent, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training



Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents receive training on Abuse recognition and prevention on an annual basis as set out in O. Reg. 79/10, s.219(1).

Through staff interview and record review it was revealed that the identified staff member has not received training on Abuse recognition and prevention since December 31, 2011. [s. 76. (7) 1.]

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 all staff who provide direct care to residents receive training on Abuse recognition and prevention on an annual basis, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131.
Administration of drugs**



Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs are administered to residents in accordance with the directions for use by the prescriber.

The physician prescribed a decrease in the dose of an identified medication by mouth at bedtime for Resident #1.

Three weeks after the identified medication was initiated the POA expressed concern that Resident #1 was experiencing increased twitching of lower extremities and inquired about the resident's medication regime.

When the Registered Staff member checked the medication pouch for the bedtime medication pass it was revealed the pouch contained half the dose that had been prescribed.

The physician was notified and orders were received to increase the dose of the identified medication at bedtime for 1 week then reassess.

The incorrect dose of the identified medication was administered to the resident as a result of a pharmacy error and numerous administration errors.

The incorrect dose was administered to Resident #1 by 6 different registered staff.

An interview with the Director of Clinical Services confirmed the medication incidents were reviewed with the staff involved.

The Consulting Pharmacist when interviewed confirmed a change to the dose of the identified medication is recommended to be implemented gradually over time. [s. 131. (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 drugs are administered to residents in accordance with the directions for use by the prescriber, to be implemented voluntarily.



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Issued on this 1st day of October, 2013

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

Lynn Parsons