Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date July 5, 2022
Inspection Number 2022_1196_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royale Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Bloomington Cove Care Community

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Lead Inspector
Eric Tang (#529)

Inspector Digital Signature

Additional Inspector(s)
Jack Shi (#760); The following inspectors: Sharon Connell (#741721), and Sarah Lee (#735818) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13, 14, 15, 16, 17, 2022.

The following intake(s) were inspected:
- An intake and CIS related to a fall with a significant change in condition.
- An intake and CIS related to a fall with a significant change in condition.
- An intake and CIS related to a fall with a significant change in condition.
- An Intake and CIS related to a fall with a significant change in condition.
- An Intake to follow up with Compliance Order (CO) #001 issued on January 28, 2022 under Inspection Report # 2022_918426_0001 related to the Ontario Regulation 79/10, s. 229 (4) with a compliance due date of March 3, 2022.
- An intake related to a change in the resident's condition.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2022_918426_0001	001	529

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184 (1).
The Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so.

Rationale and Summary
On June 13, 2022 Inspector #741721 had observed a COVID Screener did not submerge the COVID swab with the liquid buffer for two minutes on two COVID rapid tests conducted. In an interview with the IPAC Lead confirmed that staff was required to submerge the COVID swab with the buffer for two minutes as per manufacturer's instruction.

Inspector #529 made two additional observations on June 14, 2022 and the COVID Screener had performed the COVID tests correctly.

There was no impact and low risk to the residents as COVID tests were correctly performed on June 14, 2022.

Sources: Observations (June 13, & 14, 2022), and staff interview with the IPAC Lead.

Date Remedy Implemented: June 14, 2022 (529)

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *[s. 6 (7)]*

The licensee has failed to ensure the resident received an intervention as it was part of their plan of care.

Rationale and Summary

The resident had experienced a fall with injury. They also experienced a subsequent fall that resulted in a change of condition. According to the progress notes, the physiotherapist (PT) had assessed the resident and implemented an intervention which was also added to the resident's plan of care. A resident observation was made but the identified intervention was not applied. A PSW stated they had not received the intervention and therefore unable to apply it for the resident. The PSW was aware that the intervention was part of the resident's plan of care but could not explain why it was not available for the resident. An RN was unaware that the resident had such intervention, until they reviewed the resident's plan of care. The PT stated that the intervention was applied few weeks ago from the time of this observation and would have expected the staff to have implemented the intervention for the resident. The Executive Director (ED) stated that it would be the home's expectation to ensure that staff provided the identified intervention to the resident, as it was part of their plan of care. Failure to provide the resident's plan of care may result in further injury when the resident sustains a future fall.

Sources: Observation on the resident; the resident's progress notes and care plan; interviews with the ED, and other staff. (760)

WRITTEN NOTIFICATION [PAIN MANAGEMENT]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *[r. 52 (2)]*

The licensee has failed to ensure the resident received a pain assessment from a staff member after they started to complain of pain post-fall and initial interventions were ineffective.

Rationale and Summary

The resident had experienced pain in which an intervention was provided. On the next day, the resident continued to experience pain and had a change in condition. According to the home's policy, titled "Pain and Symptom Management", dated April 2019, an electronic pain assessment and a pain study tool should be utilized when the resident experiences a new onset of pain that is not relieved by pharmacological or non-pharmacological interventions. Both the pain assessment tool and pain study tool were not completed related to the pain this resident experienced. According to an RPN, a PSW brought to their attention that the resident had continued experiencing pain. However, the RPN did not perform a pain assessment on the resident and stated one should have been completed. A Clinical Care Partner confirmed that the staff should have completed a pain study tool and/or pain assessment tool electronically, based on the pain symptoms the resident had experienced after initial interventions were ineffective.

Sources: Interviews with an RPN, the Clinical Care Partner; the resident's progress notes and electronic/paper documentation; home's policy titled, "Pain and Symptom Management", dated April 2019. (760)

WRITTEN NOTIFICATION [TRANSFERRING AND POSITIONING TECHNIQUES]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *[s. 36]*

The licensee has failed to ensure that the PSW used safe positioning techniques with the resident during their care.

Rationale and Summary

A resident had experienced an injury during care provided by a PSW. The resident's care plan indicated they required a specific number of staff required for care. An RPN stated that the PSW should not have provided care to the resident without the specific number of staff members present during the care. Another PSW asserted that it would be unsafe to perform care on the resident without the specific number of staff present. The ED confirmed that the PSW did not use safe positioning techniques that aligned with their assessed needs from their care plan. Failure to use safe positioning techniques during the resident's transfer on a surface resulted in an injury.

Sources: The resident's progress notes, care plan; interview with the PSW, and other staff. (760)

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *[s. 6 (4) (b)]*

The licensee has failed to ensure that the PT and the registered staff collaborated together in the development of the resident's plan of care specifically related to their transfer status after their fall.

Rationale and Summary

An incident had occurred where the resident did not receive care with the specific amount of staff present and resulted in an injury.

The resident had a previous incident of a similar nature and the PT had performed an assessment on the resident, but this assessment did not address the number of staff this resident required for care. The PT stated that it was not their responsibility for implementing the number of staff required for resident care. The RPN revised the resident's care plan after the second incident occurred with a change in the number of staff required for this resident's care. The RPN and ED confirmed that this should have been revised after the first incident and that the home's nursing staff should have collaborated with the PT. Failure to collaborate between interdisciplinary staff resulted in unclear directions in the resident's care plan as it related to their personal care needs.

Sources: The resident's progress notes, care plan; CIS report; interviews with the PT, and other staff. (760)

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *[s. 102 (2) (b)]*

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

As per section 9.1 (b) of the IPAC Standard for Long-Term Care Homes April 2022, at minimum Routine Practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

Two Housekeepers were observed of not completing hand hygiene after removing their gloves and an interview with the IPAC Lead confirmed that hand hygiene was to be performed upon glove removal.

There was a moderate risk to the residents when the identified staff did not perform hand hygiene as expected.

Sources: Observations, and a staff interview with the IPAC Lead. (529)

WRITTEN NOTIFICATION [NUTRITIONAL CARE AND HYDRATION PROGRAMS]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *[s. 74 (2) (b)]*

The licensee has failed to ensure the programs include the identification of any risks related to nutritional care and dietary services and hydration.

Rationale and Summary

A review of the home's policy titled, "Hydration and Nutrition Monitoring" dated February 2022, stated that the nurse was to assess for signs and symptoms of dehydration and document findings in the progress note when resident had not consumed a number of servings of fluid for a number of consecutive days.

As per the resident's health records, the resident did not consume the required fluids for a consecutive number of days. Interviews with two RPNs, RD, and the Assistance Director of

Care also confirmed the same finding. The Assistant Director of Care further asserted that the nurse was required to assess the resident for signs and symptoms of dehydration, and to document the findings in their progress note. Such assessment, as per the Assistant Director of Care, was not completed and should have been completed. The resident subsequently developed a significant change in condition and diagnosed with a medical condition.

There was a moderate risk and impact to the resident. The Assistant Director of Care stated that the lack of dehydration assessment would put the resident at risk for further changes in their medical condition.

Sources: The resident's health records, home's policy titled, "Hydration and Nutrition Monitoring"; staff interviews with RD, and other staff. (529)