Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: January 18, 2024
Inspection Number: 2023-1196-0005
Inspection Type: Complaint Critical Incident Follow up
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Bloomington Cove Community, Stouffville

Lead Inspector	**Inspector Digital Signature**
Rodolfo Ramon (704757)	Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2024.02.08 14:08:17 -05'00'

Additional Inspector(s)
Eric Tang (529)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2-5, 8, and 10-12, 2024

The inspection occurred offsite on the following date(s): January 9, 2024

The following intake(s) were inspected:

- One intake was related to staff to resident alleged abuse.
- One intake was related to an injury of unknown cause
- One intake was related to staff to resident alleged abuse

- Intake: #00098025 - First follow up - Compliance Order (CO) #001/Inspection #2023-1196-0003, related to O. Reg. 246/22, s. 276 (1), with Compliance Due Date (CDD) of October 20, 2023.
- One intake was related to resident to resident abuse.
- One intake was a complaint related to abuse
- One intake was a complaint related to responsive behaviours, neglect, medication administration, and continence care.
- One intake was related to a disease outbreak
- One intake was related to a fall resulting in fracture

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1196-0003 related to O. Reg. 246/22, s. 276 (1) inspected by Rodolfo Ramon (704757)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A complaint and a Critical Incident Report (CIR) were submitted to the Ministry of Long-Term Care (MLTC) alleging a resident was physically abused by a staff.

Personal Support Workers (PSWs) #102 and #103 worked a shift in the same resident home area on an identified date. As per the home's internal investigation notes, PSW #103 had alleged PSW #102 of physical abuse. PSW #103 reported to their on-duty nurse immediately, but only alleging PSW #102 speaking loudly when working on the floor. The specifics of the allegations were not reported to the home until weeks later by sending an electronic communication to the home's team member experience coordinator.

The home's policy on prevention of abuse and neglect of a resident instructed staff to immediately report suspected or witnessed abuse and neglect to the resident home area's charge nurse.

PSW #103 was aware that they had to immediately report to the charge nurse of the home area for any suspected or witnessed abuse and neglect. The staff admitted that they did not disclose their concerns to the home until weeks later. The Administrator further confirmed that the home's written policy to promote zero

tolerance of abuse and neglect of residents was not complied with.

Failure to not report suspected abuse and neglect of residents immediately might result in potential risks and harms to the residents, and delayed the home in taking appropriate actions to protect the residents.

Sources: The resident's electronic health records, home's internal investigation notes, and interviews with PSW #103 and the Administrator.
[529]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident was exhibiting altered skin integrity that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A CIR was submitted to the MLTC stating a resident had sustained an unwitnessed fall with injury.

The home's internal investigation notes and the resident's electronic health records indicated the resident was found on the floor. The resident was then sent to a local medical facility for additional assessment and treatment.

As per the resident's electronic health records, a procedure was completed and the resident returned to the long-term care home (LTCH) weeks later with a wound covered with dressing.

The home's skin and wound care management policy instructed the registered staff to complete an electronic skin and wound assessment upon the discovery of an altered skin integrity.

The resident's electronic health records did not contain documentation of the skin and wound upon readmission.

The IDOC confirmed that surgical wound was a type of altered skin integrity in which a skin and wound assessment was to be completed electronically by the registered nursing staff upon discovery. The IDOC further confirmed that the required skin and wound assessment was not completed.

There was a risk and impact to the resident as the resident's wound condition might not have been assessed and documented, thereby potentially impacting the care team's understanding of the resident's wound condition.

Sources: The resident's electronic health records, home's internal investigation notes, and interview with IDOC.
[529]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that for a resident demonstrating responsive behaviours, strategies were implemented to respond to these behaviours

Rationale and Summary
A complaint was submitted to the MLTC regarding multiple concerns including an incident where an altercation took place between residents #007 and #009.

Resident #007's plan of care indicated they had history of responsive behaviours and included interventions to manage their behaviours. Registered Nurse (RN) #111 and the IDOC confirmed that the intervention in the care plan was required to be implemented at all times.

PSW #110 confirmed that they witnessed the altercation between residents #007 and #009 and verified the intervention in the care plan was not implemented for resident #007.

Failing to implement the care plan intervention placed resident #009 at risk of injury.

Sources: Resident #007's plan of care, interviews with PSW #110, RN #111 and the IDOC.
[704757]

WRITTEN NOTIFICATION: Medication Management System

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

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the Medication Management System policies and protocols were implemented.

Rationale and Summary
A complaint was submitted to the MLTC regarding multiple concerns including a medication incident involving a resident. According to the complainant, the resident received an increased dose of a medication.

The resident's Medication Administration Record (MAR) indicated that for 13 days, there were two active duplicate orders of a medication at a specified medpass. According to the MAR, on two occasions, the registered staff documented to have administered two doses of the medication.

According to the New Medication Orders policy, when a new medication order is received by the nurse, two independent checks must be completed. During the first and second check, the nurses were required to remove any changed medication.

The IDOC informed the inspector that the home was unable to determine if the resident did receive both doses of the medication, and confirmed the medication management policies and procedures were not followed when the order of the medication was changed. The nurses who completed the first and second check were expected to place on hold the duplicate order.

Failing to follow the policies and procedures placed the resident at risk of adverse effects.

Sources: New Medication Orders policy 4.2, the resident's MAR, and interview with the IDOC.
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