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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Original Public Report

Report Issue Date: May 29, 2024	
Inspection Number: 2024-1196-0001	
Inspection Type: Critical Incident	
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 Eric Tang (529)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23 - 24, 28, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:
An intake and a CI were related to a falls prevention and management.

An intake and a CI were related to infection prevention and control.

An intake and a CI were related to prevention abuse and neglect.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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 that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director where the resident alleged that they were physically abused by the staff of the long-term care home (LTCH).

Based on the resident's records, an on-duty registered nursing staff was informed of the allegation during their shift. An investigation was immediately carried out and a conclusion was made about the allegation. The staff did not proceed to report the allegation to the Charge Nurse or the LTCH management. It was not until the following day when the resident's family contacted another registered nursing staff about the matter and the nurse then immediately reported it to the management team.

As per the home's policy on prevention of abuse and neglect of a resident, any allegation of suspected or witnessed of abuse and neglect was to be immediately reported to the Charge Nurse in the community.

The Assistant Director of Care (ADOC) confirmed the same and that the registered nursing staff was expected to immediately report the allegation to the Charge Nurse and the On-Call Manager during their shift. The ADOC further confirmed that the registered nursing staff did not comply with the home's policy on prevention of abuse and neglect in relation to reporting.

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

Sources: CIR, home's internal investigative notes, the resident's electronic health records, and staff interview. [529]