Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2020	2020_669642_0016	003049-20, 007455-20, 008594-20, 009087-20, 009325-20, 015175-20, 015412-20, 016720-20	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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

AMY GEAUVREAU (642), AMANDA BELANGER (736), HILARY ROCK (765), KEARA CRONIN (759), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 14-18, 2020, onsite, and September 21-25, 2020, was off-site.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

-One Log, related to medication.

-Two Logs, related to a fall with injury.

-Two Logs, related to an injury from a unknown cause.

-Two Logs, related to alleged abuse from staff to resident.

-One Log, related to alleged abuse from resident to resident.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 20 (1) was identified in a concurrent inspection #2020_229213_0015, and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim ED, Director of Care (DOC), Assistant Director of Care's (ADOCs), Physician, Nurse Practitioner, Registered Dietician (RD), Behavioural Support Resource Team (BSRT), Resident and Family Experience Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Aids (CSAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **5 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 was protected from physical abuse by Personal Support Worker (PSW) #138 on a specific date.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

On a specific date, resident #011 reported to Registered Nurse (RN) #105, that they had been involved in an incident with a staff member and had injuries from the incident. The RN completed an assessment on resident #011.

A review of the homes investigation notes identified the Director of Care (DOC) had emailed the Assistant Director of Care (ADOC) #139 to review the video footage from that specific day. After reviewing the video footage the ADOC had identified the incident.

An interview with PSW #123, stated they had worked on that specific day, with PSW #122. They had seen resident #011 come out of their room and they had been upset. PSW #123 stated they did see the injury, but since PSW #138 was resident #011's primary PSW, they thought PSW #138 would report the injury. PSW #123 and #122 did not report the incident to a nurse.

A review of the investigation documents completed by the DOC identified that on a specific day, the day shift RN #124 had not been informed of resident #011’s injury, or that the resident had been upset.The evening shift RN #140 had a routine assessment that had been completed for resident #011 on that specific day, when the injuries where identified. RN #140 had not been aware of any incident, and had informed the Substitute Decision Maker (SDM) that the injuries were from an unknown cause.

The DOC stated that after the home had investigated the incident, the allegation of physical abuse from PSW #138 to resident #011 was founded, and the staff member was terminated.

Sources: The home's investigation documents; Prevention of Abuse & Neglect of a Resident policy; resident #011’s progress notes; and interviews, with DOC, and other staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that were to be destroyed, were stored in an area that was secure and locked.

a) Medications which were to be discarded were observed in an unsecured container, in an unlocked cupboard in specific areas of the home. The discarded medications were observed in their original strip packaging. The lid of the containers were not secured, and could be easily removed.

b) A wooden double locked box, for the disposal of medications, was observed in a specific area, in an unlocked cupboard. The Inspector was able to remove discarded medications from the opening of the wooden box.

c) A wooden double locked box, for the disposal of medications, was observed beside the medication cart, in a specific home area. The wooden box was not secured to the floor or the wall. The Inspector was able to remove discarded medications from the opening, prior to the container being emptied.

The ADOC #111 acknowledged that the medications should be removed from their original packaging, prior to being disposed of in the container, with the lid secured. The ADOC observed the Inspector remove medications from the double locked wooden box.

The pharmacist consultant acknowledged that medications to be discarded should be removed from their original strip packaging and be discarded in the container, which should be sealed and stored in a locked cupboard. They also acknowledged that the wooden double locked box which was stored beside the medication cart could be carried away as it was unsecured, and that they would discuss with head office on how to ensure that medications were not removed from the opening, if the boxes were overfilled.

The medications, to be discarded were not accessible to residents. No harm came to the residents.

Sources: The home’s policy titled, “Drug Destruction and Disposal”, last revised February 2020; observations completed; interviews with ADOC #111, and Pharmacist consultant and other staff. [627] [s. 129. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's zero tolerance of abuse policy was complied with, related to the investigation into improper or incompetent care of resident #001.

The licensee's policy titled "Prevention of Abuse and Neglect of a Resident", indicated that the Executive Director, or designate would initiate an investigation into allegations of improper or incompetent care, and that statements and interviews would take place with any persons who may have had knowledge of the situation.

In separate interviews with PSW #116, and RPN #134, who had originally identified the injury for resident #001, indicated that they had not been interviewed related to the injury of an unknown cause for the resident.

Inspector #736 reviewed the investigation file provided by the home, related to the allegation of improper or incompetent care of resident #001, related to an unknown injury. The Inspector noted that there were no statements from any persons who may have had knowledge of the situation.

Sources: Resident #001's progress notes; internal investigation folder; licensee's policy titled "Prevention of Abuse and Neglect of a Resident"; interviews with PSW #116 and RPN #134, and other staff. [736] [s. 20. (1)]

2. The licensee has failed to ensure that a Care Support Aid (CSA) #113, who had reasonable grounds to suspect alleged abuse from PSW #114 towards resident #009 and #010, should have complied with the home's Abuse policy.

A Critical Incident (CI) report was submitted on a specific day, to the Director alleging that PSW #114 had abused resident #009 and #010 sometime between two specific dates. The home's investigation notes identified CSA #113 had not reported the allegations until weeks after the suspected incidents.

The home's policy required all team members to immediately report any suspected or known incident of abuse to the Executive Director (ED) or designate. The DOC stated after their investigation into the incident, the abuse was unfounded, but acknowledged that CSA #113, should have reported the allegations of abuse, immediately. There was minimal risk of harm towards resident #009 and #010.

Sources: CI report; the home's Prevention of Abuse and Neglect of Resident policy; investigation notes; interview with CSA #113, and DOC and other staff members. [s. 20. (1)]

3. The licensee has failed to ensure that PSW #122 and #123 reported alleged physical abuse when resident #011 identified an injury and had been upset.

See WN #1 for full details of this incident.

An interview with PSW #123, stated they had worked on a specific date, with PSW #122. They had seen resident #011 come out of their room and were upset. PSW #123 stated they did see resident #011's injury, but since PSW #138 was resident #011's primary PSW, they thought PSW #138 would report it. PSW #123 and #122 did not report the incident to a nurse.

The DOC stated that after the home had investigated resident #011's physical abuse allegation, they found that the incident had actually happened on a specific number of days before. PSW #122 and #123 failed to report the allegation of abuse the day it happened.

Sources: The home's investigation records; Prevention of Abuse & Neglect of a Resident policy; resident #011's progress notes; and interviews, with DOC, and PSW #123 and other staff. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #004 and #005.

Resident #004's care plan indicated for staff to, "keep resident and co-resident away from each other on the unit."

Resident #005's care plan indicated that, staff are to, "redirect me away from other co-residents when I am within close proximity to co-resident."

Behavioural Support Resource Team (BSRT) Lead #129 and ADOC #117 verified that the care plan was not clear, because it did not say who the interventions were referring to specifically.

Sources: Resident care plan's; and intervention plan from the BSRT; interviews with BSRT Lead #129 and ADOC #117. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of resident #003, resulting in an injury, would report the suspicion and information to the Director immediately.

A Critical Incident (CI) report was submitted to the Director on a specific day. A review of the CI and progress notes had identified resident #003 had first showed signs of an injury on a specific day, the x-ray results indicated that resident #003 had sustained a specific injury. The home did not report the suspected improper care or start their investigation until days later. The Executive Director (ED) stated that immediate reporting and investigation should have occurred. The Interim (ED) confirmed that this CI was not submitted immediately.

Sources: Progress notes on point click care, CI report, and interview with Interim ED #100 and ED #130 [765] [s. 24. (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 that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002 had fallen, the post-fall assessment which included the head injury routine (HIR) had been conducted using a clinically appropriate assessment instrument.

On a specific day, resident #002 sustained a fall, and was found by staff; the progress note indicated that the HIR form was initiated. A review of the HIR form, showed that a specific number of the HIR checks were not documented by staff.

In separate interviews with RPN #109, and ADOC #102, they reviewed the HIR form for resident #002, and noted that it was not completed in its entirety. ADOC #102 indicated that the HIR form was part of the post fall assessment for a resident, and if the HIR form was not completed, then the post fall assessment had not been fully completed for resident #002.

Sources: Resident #002's progress notes; and Head Injury Routine form; falls policy; interviews with RPN #109, and ADOC #102, as well as other staff. [s. 49. (2)]

2. The licensee has failed to ensure that when resident #005 had fallen, the post-fall assessment, which included the head injury routine (HIR) had been conducted using a clinically appropriate assessment instrument.

On a specific day, resident #005 had an incident with resident #004; the progress notes indicated that the HIR form was initiated. A review of the HIR form showed, that a specific number of checks were not documented by staff.

During an interview with ADOC #102, they reviewed the HIR form for resident #005, and noted that it was not completed in its entirety. ADOC #102 indicated that the HIR form was part of the post fall assessment for a resident, and if the HIR form was not completed, then the post fall assessment had not been completed for resident #005.

Sources: Resident #005's progress notes; and Head Injury Routine form; falls policy; interviews with ADOC #102, as well as other staff. [s. 49. (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 when a resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post-fall assessment are fully conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that resident #011 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for an injury identified by PSWs #122 and #123.

Resident #011 sustained a injury after an incident. An interview with PSW #123, stated they were working on the specific day, with PSW #122, when they saw resident #011 come out of their room. They stated they did see the injury, but since PSW #138 was resident #011's primary PSW, they thought PSW #138 would report it. PSW #123, and #122, did not report the injury to a nurse.

The Investigation records completed by the DOC identified the day shift RN #124 had not been informed of resident #011’s injury by PSW #122, and #123. The evening shift RN #140 had completed a routine assessment for resident #011, the document identifies the injury was assessed and treated many hours later, when it should have been treated immediately.

Sources: The home's investigation notes; Skin & Wound Care Management Protocol Policy; skin and wound assessments; resident #011’s progress notes; and interviews, with PSW #123 and other staff. [s. 50. (2) (b) (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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to resident #007, unless the drug was prescribed.

RPN #118 administered a specific medication to resident #007, although the medication was not prescribed for this resident. The resident was sent to the hospital to be monitored. The resident was not harmed.

RPN #118 acknowledged giving resident #007 the wrong medication and that that this medication was not prescribed for this resident.

Sources: CI report; resident #007's Medical Administration Record (MAR); interviews, with RPN #118 and other staff. [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed to the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions that were taken to meet the needs of resident #004, who had specific behaviours, included documentation of the resident's responses to the interventions.

Resident #004's Team Behaviour Debriefing Tool and Responsive Behaviour Referral indicated that behaviour tracking was to occur each shift for a certain number of days. The Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) data collection sheet that was started on a specific day, had incomplete documentation. A review of the tool with RPN #128 verified that the BSO-DOS form should have been completed in its entirety.

Sources: Resident #004's Team Behaviour Debriefing Tool and Responsive Behaviour Referral; BSO-DOS data collection sheet; and interviews with RPN #128 and other staff. [s. 53. (4) (c)]

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Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 6th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMY GEAUVREAU (642), AMANDA BELANGER (736), HILARY ROCK (765), KEARA CRONIN (759), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2020_669642_0016
Log No. / No de registre :	003049-20, 007455-20, 008594-20, 009087-20, 009325-20, 015175-20, 015412-20, 016720-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 23, 2020
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Bradford Valley Care Community 2656 6th Line, Bradford, ON, L3Z-2A1
	Cathy VanBeek

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1), of the LTCHA.

Specifically, the licensee must:

1) Ensure that all residents are protected from abuse by anyone, and from neglect by the licensee or staff.

2) Educate PSW #122, and #123 on the home's abuse policy.

3) Document the education completed, including the date and the staff member who provided the education. Provide the documentation when requested by the Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #011 was protected from physical abuse by Personal Support Worker (PSW) #138 on a specific date.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

On a specific date, resident #011 reported to Registered Nurse (RN) #105, that they had been involved in an incident with a staff member and had injuries from the incident. The RN completed an assessment on resident #011.

A review of the homes investigation notes identified the Director of Care (DOC) had emailed the Assistant Director of Care (ADOC) #139 to review the video

footage from that specific day. After reviewing the video footage the ADOC had identified the incident.

An interview with PSW #123, stated they had worked on that specific day, with PSW #122. They had seen resident #011 come out of their room and they had been upset. PSW #123 stated they did see the injury, but since PSW #138 was resident #011's primary PSW, they thought PSW #138 would report the injury. PSW #123 and #122 did not report the incident to a nurse.

A review of the investigation documents completed by the DOC identified that on a specific day, the day shift RN #124 had not been informed of resident #011's injury, or that the resident had been upset.The evening shift RN #140 had a routine assessment that had been completed for resident #011 on that specific day, when the injuries where identified. RN #140 had not been aware of any incident, and had informed the Substitute Decision Maker (SDM) that the injuries were from an unknown cause.

The DOC stated that after the home had investigated the incident, the allegation of physical abuse from PSW #138 to resident #011 was founded, and the staff member was terminated.

Sources: The home's investigation documents; Prevention of Abuse & Neglect of a Resident policy; resident #011's progress notes; and interviews, with DOC, and other staff.

An order was made by taking the following into account:

Severity: PSW #122, and #123, were informed by resident #007, that they had an injury. There was actual risk of harm to the resident, because no one had reported the incident.

Scope: This was an isolated case as no other incidents of physical abuse were identified during this inspection.

Compliance History: Three voluntary plans of corrections (VPCs) were issued to the home related to the same sections of the legislation in the past 36 months. (642)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 11, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 129. (1),

Specifically, the licensee must:

1) Ensure that all controlled substances that are to be destroyed are stored in a secure container, that is in a locked cupboard or secured to the floor or wall.
2) Ensure that drugs disposed of in the secure container cannot be removed from the opening of the container.
3) Ensure that all regular medication tablets that are to be destroyed, are removed from the packaging and discarded in a secure container that is stored in a secured cupboard.
4) Re-educate all registered staff on the home's policy and procedure for the disposal of medications that are to be destroyed, and keep a record.
5) Complete weekly audits for one month to ensure that the home's policy and procedure for the disposal of medications is complied with. The audit will be documented with the name of the designated person completing the audit. Copies of the audits will be provided to the Inspector upon request.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that drugs that were to be destroyed, were stored in an area that was secure and locked.

a) Medications which were to be discarded were observed in an unsecured container, in an unlocked cupboard in specific areas of the home. The discarded medications were observed in their original strip packaging. The lid of the containers were not secured, and could be easily removed.

b) A wooden double locked box, for the disposal of medications, was observed in a specific area, in an unlocked cupboard. The Inspector was able to remove discarded medications from the opening of the wooden box.

c) A wooden double locked box, for the disposal of medications, was observed beside the medication cart, in a specific home area. The wooden box was not secured to the floor or the wall. The Inspector was able to remove discarded medications from the opening, prior to the container being emptied.

The ADOC #111 acknowledged that the medications should be removed from their original packaging, prior to being disposed of in the container, with the lid secured. The ADOC observed the Inspector remove medications from the double locked wooden box.

The pharmacist consultant acknowledged that medications to be discarded should be removed from their original strip packaging and be discarded in the container, which should be sealed and stored in a locked cupboard. They also acknowledged that the wooden double locked box which was stored beside the medication cart could be carried away as it was unsecured, and that they would discuss with head office on how to ensure that medications were not removed from the opening, if the boxes were overfilled.

The medications, to be discarded were not accessible to residents. No harm came to the residents.

Sources: The home's policy titled, "Drug Destruction and Disposal"; observations completed; interviews with ADOC #111, and Pharmacist consultant and other staff. [627]

An order was made by taking the following factors into account:

Severity: Non-compliance identified in the medication rooms, including medications to be discarded were not accessible to residents. There was no risk of harm to the residents.

Scope: The scope was widespread because three out of three medication rooms observed, were identified to have non-compliance with securing their medications that were ready for destruction.

Compliance History: Two voluntary plans of corrections (VPCs) were issued to the home related to previous non-compliance to the same subsection.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:

1. 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.

i) Report improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;

ii) Report abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident;

2) Re-educate, Nurse Managers, PSW #122, #123, CSA #113 and new staff, on the requirements under s. 20 (1), and ensure that the zero tolerance of abuse and neglect of residents is complied with.

3) Document who provided the re-education: the date the education was completed; and who completed the education. This documentation will be provided to the Inspector, upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's zero tolerance of abuse policy was complied with, related to the investigation into improper or incompetent care of resident #001.

The licensee's policy titled "Prevention of Abuse and Neglect of a Resident", indicated that the Executive Director, or designate would initiate an investigation into allegations of improper or incompetent care, and that statements and interviews would take place with any persons who may have had knowledge of the situation.

In separate interviews with PSW #116, and RPN #134, who had originally identified the injury for resident #001, indicated that they had not been interviewed related to the injury of an unknown cause for the resident.

Inspector #736 reviewed the investigation file provided by the home, related to the allegation of improper or incompetent care of resident #001, related to an unknown injury. The Inspector noted that there were no statements from any persons who may have had knowledge of the situation.

Sources: Resident #001's progress notes; internal investigation folder; licensee's policy titled "Prevention of Abuse and Neglect of a Resident"; interviews with PSW #116 and RPN #134, and other staff. [736] (642)

2. The licensee has failed to ensure that a Care Support Aid (CSA) #113, who had reasonable grounds to suspect alleged abuse from PSW #114 towards resident #009 and #010, should have complied with the home's Abuse policy.

A Critical Incident (CI) report was submitted on a specific day, to the Director alleging that PSW #114 had abused resident #009 and #010 sometime between two specific dates. The home's investigation notes identified CSA #113 had not reported the allegations until weeks after the suspected incidents.

The home's policy required all team members to immediately report any suspected or known incident of abuse to the Executive Director (ED) or designate. The DOC stated after their investigation into the incident, the abuse was unfounded, but acknowledged that CSA #113, should have reported the allegations of abuse, immediately. There was minimal risk of harm towards resident #009 and #010.

Sources: CI report; the home's Prevention of Abuse and Neglect of Resident

policy; investigation notes; interview with CSA #113, and DOC and other staff members. (642)

3. The licensee has failed to ensure that PSW #122 and #123 reported alleged physical abuse when resident #011 identified an injury and had been upset.

See WN #1 for full details of this incident.

An interview with PSW #123, stated they had worked on a specific date, with PSW #122. They had seen resident #011 come out of their room and were upset. PSW #123 stated they did see resident #011's injury, but since PSW #138 was resident #011's primary PSW, they thought PSW #138 would report it. PSW #123 and #122 did not report the incident to a nurse.

The DOC stated that after the home had investigated resident #011's physical abuse allegation, they found that the incident had actually happened on a specific number of days before. PSW #122 and #123 failed to report the allegation of abuse the day it happened.

Sources: The home's investigation records; Prevention of Abuse & Neglect of a Resident dated April 2019; resident #011's progress notes; and interviews, with DOC, and PSW #123 and other staff. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

Service Area Office /
Bureau régional de services : Central East Service Area Office