Ontario

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

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

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Original Public Report

Report Issue Date: March 13, 2023	
Inspection Number: 2023-1389-0002	
Inspection Type: Critical Incident System	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development	
Long Term Care Home and City: Bradford Valley Care Community, Bradford	
Lead Inspector Vernon Abellera (741751)	**Inspector Digital Signature** Vernon Abellera Digitally signed by Vernon Abellera Date: 2023.03.23 13:44:52 -04'00'
Additional Inspector(s) Carole Ma (741725)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
February 6-9, 13-16, 2023, with February 7 and 15, 2023, conducted off-site.

The following intake(s) were inspected:
Two intakes related to falls with injury.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: COMPLIANCE WITH MANUFACTURER'S INSTRUCTIONS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26

The licensee failed to ensure that staff used the COVID-19 rapid antigen test (RAT) in accordance with manufacturer's instructions.

Rationale and Summary

The Inspector observed a Personal Support Worker (PSW) performing the RAT on themselves and leaving the swab in the solution for less than two minutes.

The manufacturer's instructions for the RAT stated that after the swab was mixed well and compressed against the walls of the tube, the swab should stand in the solution for two minutes. The home provided a step-by-step instructions poster in the swabbing area entitled, "How to Use The Rapid Antigen Test Kit", which stated the swab should be left in the liquid solution for two minutes.

The Infection Prevention and Control (IPAC) lead stated the expectation was for staff to follow manufacturer's instructions by letting the swab stand in the solution for two minutes when self-administering the RAT.

Failure to follow the manufacturer's instructions presented a risk of false results that could lead to the spread of infectious agents, such as, COVID-19 in the home.

Sources: Observation, COVID-19 Antigen Rapid Test Device manufacturer's instructions, "How to Use The Rapid Antigen Test Kit" poster, and interview with the IPAC Lead. (#741751)

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home is carried out.

In accordance to the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective August 30, 2022, which references the COVID-19 Guidance document for Long-Term Care Homes in Ontario, the licensee was required to ensure that residents in

isolation are not to join in group dining gatherings. This guidance document further references the Ministry of Health's COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and other Congregate Living Settings for Public Health Units document which states that residents who are identified as positive for infection must self-isolate for at least 10 days. The licensee failed to comply when a resident who was confirmed positive for infection and placed under additional precautions, was permitted to enter, and remained in the dining room during lunch service.

Rationale and Summary

A resident was tested positive for infection and their medical records confirmed additional precautions were still in place on the day of the observation.

The resident was assisted to the dining room by a PSW during lunch service, while co-residents were also in attendance. The Registered Nurse (RN) directed the resident to sit at a table alone, away from other residents in the dining room who were eating lunch. The PSW brought the resident a surgical mask to wear, however, it was soon lowered to their chin as the resident wiped their nose and continued to sit at the table for at least another 15 minutes. The resident did not eat lunch during this time. The RN also confirmed the resident was positive for infection.

The IPAC lead stated that residents who were confirmed positive for infection should be isolated in their rooms to prevent the spread of infection.

In permitting a positive resident for infection into the dining room during lunch service, the residents in the shared space were put at risk of infection transmission.

Sources: Observations, resident's electronic medical records, interviews with RN and IPAC lead. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that a resident's symptoms indicating the presence of infection were monitored on every shift.

Rationale and Summary

The Inspector reviewed the home's COVID-19 influenza investigation line listing form, which indicated a resident was confirmed positive for infection and exhibited symptoms. The resident's progress notes indicated their infectious symptoms were not monitored and documented for five shifts.

The Assistant Director of Care (ADOC) stated the expectations were to monitor all residents presenting with symptoms and to document appropriately in PointClickCare on every shift.

Failure to monitor the resident's infectious symptoms every shift increased the risk of an unidentified worsening condition for the resident.

Sources: Resident's clinical record and interview with the ADOC [741751]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary

1) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 6.1

In the IPAC Standard for Long-Term Care Homes, dated April 2022, section 6.1 states the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply in place and ensuring adequate access to PPE for routine practices and additional precautions.

During the Inspector's rounds on the three COVID-19 outbreak home areas, several PPE caddies were not fully stocked. Some residents' rooms had no gloves and face shields available.

The PSWs, RN, and the IPAC lead confirmed that all the staff on the floor were responsible for replenishing the PPE stock in the caddies. Additional PPE stocks were available on each unit.

Failure to comply with IPAC standards and protocols related to PPE stocks availability and accessibility, put residents and staff at risk from possible transmission of infectious agents, such as, COVID-19.

Sources: Observations, interviews with the PSW, RN and IPAC lead. [741751]

2) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 9.1, Routine Practices (b)

In accordance with the IPAC Standard for Long Term Care Homes, dated April 2022, section 9.1 (b) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include hand hygiene, including, but not limited to, 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).

During lunch service, multiple staff were observed assisting residents in two outbreak units.

A PSW was observed serving meals to residents and clearing the dishes at the same time, without performing hand hygiene. The PSW interacted and had contact with more than two residents in the dining room while performing these tasks. They confirmed they should have completed hand hygiene when serving food and clearing the dishes. Another PSW was also observed in a dining room to have had interactions with multiple residents and their environment without conducting hand hygiene in between contacts. Alcohol-based hand rub (ABHR) was readily available in the dining rooms.

The IPAC lead confirmed the observations did not meet the home's expectations for performing hand hygiene in accordance with the four moments and posed a risk of spreading infections,

including COVID-19, to residents.

Sources: Observations, interviews with PSW and the IPAC lead. [741751] [741725]

3) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 9.1, Routine Practices (d)

In accordance with the IPAC Standard, section 9.1 (d) directs the licensee to ensure that Routine Practices were followed in the IPAC program. At minimum, Routine Practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

A PSW was observed wearing two surgical masks while in the hallway of a COVID-19 outbreak unit. The PSW confirmed that they were wearing two surgical masks for additional protection due to their health condition.

The IPAC lead confirmed that wearing two surgical masks was not within their expectations for staff and confirmed that there had not been any special accommodation request from staff related to masking and health conditions.

Failure to use PPE appropriately increased the risk of spreading infectious diseases, including COVID-19, in the home.

Sources: Observation, interviews with PSW, and the IPAC lead. [741751]

4) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 9.1, Additional Precautions (f)

In accordance with the IPAC Standard, section 9.1 Additional Precautions (f) states, the licensee shall ensure that Additional Precautions are followed in the IPAC program. Additional Precautions shall include Additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

The Administrator and IPAC lead shared that the home had been on COVID-19 outbreak in three resident home areas (RHA) since December 2022 and continued to be on outbreak at the time of the inspection. Only resident rooms placed on additional precautions required full PPE upon entry. In common areas of these outbreak units, wearing a surgical mask and face shield

were required.

Numerous observations were made where staff and visitors were not wearing the appropriate PPE while on an outbreak unit. They are detailed as follows:

-In multiple resident rooms on additional precautions, staff and a visitor were observed not wearing the appropriate PPE.

-In several areas in the home including the residents' dining room and hallways, multiple staff and a visitor were observed not wearing a face shield.

In addition, an observation related to improper PPE removal and disposal was made. Two housekeepers were observed exiting residents' rooms that were on additional precautions. The housekeepers doffed their PPE outside of the rooms. A hamper bin for disposing of reusable gowns was not available inside the resident room, so the housekeeper walked down the hallway carrying their soiled gown and deposited it into a hamper bin located at the end of the hallway.

The IPAC lead stated staff and visitors were required to wear a surgical mask and face shield when on COVID-19 outbreak units. The IPAC lead also confirmed that additional precautions should be followed which included appropriate PPE selection, removal, and disposal.

Additional precautions were implemented as part of the home's IPAC program to reduce the spread of COVID-19. Not adhering to the appropriate additional precautions related to PPE use, may put residents at risk for infections, including COVID-19.

Sources: Observations, interviews with IPAC lead, visitors, PSWs and a Care Support Assistant. [741751] [741725]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, who was at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return from facility.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to a resident who fell and was transferred to another facility for further intervention. The resident was at risk for altered skin integrity due to the injury. The resident returned to the home with altered skin integrity.

Review of the resident's medical records revealed there was no documentation of a skin assessment completed upon the resident's return from the facility. An RN and the ADOC also confirmed this from their own record review.

By not conducting a skin assessment on the resident upon return from the facility, the home failed to follow up on their altered skin integrity and establish a baseline, which potentially resulted in delay of treatment and compromised healing.

Sources: CIR, resident's medical records, interviews with RN and ADOC. [741725]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that two residents with altered skin integrity were assessed using a clinically appropriate skin and wound assessment instrument by a registered nursing staff.

Rationale and Summary

1) A CIR was submitted to MLTC related to a resident who fell and was transferred to another facility for further intervention. The resident's medical records indicated the resident returned to the home with areas of altered skin integrity.

A review of the resident's medical records revealed that the skin assessment had not been conducted on the areas of altered skin integrity using the home's skin and wound application. The skin and wound application was to be used to assess and monitor the altered skin issue by registered nursing staff. An RN also confirmed through their own record review that this assessment had not been conducted.

Failure to conduct a skin assessment on the altered skin integrity sustained by a resident, prevented the home from establishing a baseline of the wound, and potentially lead to a delay in implementing interventions and treatments which compromised wound healing.

Sources: CIR, resident's medical records, interview with RN. [741751]

2) A CIR was submitted to the MTLC related to a resident who fell and was transferred to another facility for further intervention. The resident was at risk for altered skin integrity. The resident returned to the home with altered skin integrity due to injury.

Review of the resident's medical records revealed that a skin assessment had not been conducted for this area of altered skin integrity using the home's skin and wound application. An RN and the ADOC also confirmed through their own record review that this assessment had not been conducted for the same duration.

The area of altered skin integrity had worsened and required further treatment.

Failing to conduct a skin assessment on the known altered skin sustained by the resident, prevented the home from establishing a baseline of the wound, and potentially lead to a delay in implementing interventions for wound healing.

Sources: CIR, resident's medical records, interviews with RN and ADOC. [741725]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure two residents' areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

1) A CIR was submitted to MLTC related to a resident who fell and was transferred to another facility for further interventions. The resident's medical records indicated the resident returned to the home with areas of altered skin integrity.

Review of the resident's medical records revealed that weekly skin assessments had not been

initiated and conducted for these two altered skin areas using the home's skin and wound application. An RN also confirmed through record review that weekly skin assessments had not been conducted to date.

Failure to conduct weekly skin assessments on the altered skin integrity of the resident prevented the home from monitoring the wound, and lead to a delay in implementing interventions and treatments which may have compromised wound healing.

Source: CIR, resident's medical records, interview with RN. [741751]

2) A CIR was submitted to the MTLC related to a resident who fell and was transferred to another facility for further intervention. The resident was at risk for altered skin integrity. The resident returned to the home with altered skin integrity due to their injury.

Review of the resident's medical records revealed that weekly skin assessments had not been conducted for this altered skin using the home's skin and wound application. An RN and the ADOC also confirmed through their own record review that weekly skin assessments had not been conducted for the same duration.

The area of altered skin integrity had worsened and required further treatment.

Failing to conduct weekly skin assessments on the known altered skin areas prevented the home from monitoring the wound, implementing interventions and treatments, and compromised and delayed wound healing.

Source: CIR, resident's medical records, interviews with RN and ADOC. [741725]