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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 29, 2023
Inspection Number: 2023-1389-0003
Inspection Type: Complaint 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	**Inspector Digital Signature**
Jennifer Brown (647)	Jennifer Brown

Additional Inspector(s)
Parimah Oormazdi (741672)
Suzanna McCarthy (000745)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, 31, 2023, and June 1, 2, 5, 6, 7, 8, 2023.

The following intake(s) were inspected:

- Two intakes were related to falls,
- Two intakes were related to abuse, neglect and plan of care,
- One intake was related to an improper transfer,
- One intake was related to an unknown injury.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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)
LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

Non-compliance with: LTCHA, 2007, s. 6 (10)(b)
The licensee has failed to ensure that a resident's plan of care was updated and revised when their level of care needs changed.

Rationale and summary:
A complaint was submitted to the Director related to concerns with a resident's care. Through review of the resident's assessments, it was identified that the resident required two staff members assistance to complete a specified task, however their care plan indicated that they required one staff assistance.

A staff member confirmed that the resident's care level needs changed to two staff assistance, however their care plan had not been updated or revised. Following the interview with the staff member, the resident's care plan was updated.

Source: Clinical records, interview with applicable staff. [741672]

Date Remedy Implemented: June 6, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

Non-compliance with: LTCHA, 2007, s. 6 (10)(b)
The licensee has failed to ensure that a resident's plan of care was updated and revised when their level of continence care changed.

Rationale and summary
A complaint was submitted to the Director related to concerns with a resident's continence care. Through review of the resident's assessments, it was identified that their level of continence care had changed, however their care plan did not. The staff member who had completed the assessment, indicated that they did not revise the care plan when the resident's level of continence changed. Following the interview with the staff member, the resident's care plan was updated.

Source: Clinical records, interview with applicable staff.

[741672]

Date Remedy Implemented: June 5, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (5)

Non-compliance with: LTCHA, 2007, s. 6 (5)
The licensee has failed to ensure that a resident and their Substitute Decision Maker (SDM) were involved when a dietary intervention was discontinued.

Rationale and summary
A complaint was submitted to the Director related to concerns with a resident's nutritional care. Through review of the resident's electronic progress notes it was identified that a dietary intervention was implemented, with involvement of the resident and their SDM. The quarterly nutrition assessment indicated that the dietary intervention was discontinued. There were no records indicating that the resident and SDM were involved in discontinuing the intervention.

A staff member indicated that they discontinued the dietary intervention, however they did not discuss it with the SDM.

Following the interview with the staff member, they informed the home to not discontinue the dietary intervention until they discuss with the SDM.

Source: Clinical records, interview with applicable staff members.
[741672]

Date Remedy Implemented: June 7, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

Non-compliance with: LTCA, 2007, s. 6 (7)
The licensee has failed to ensure that the skin and wound treatment set out in the plan of care was provided to a resident as specified in the plan.

Rationale and summary
A complaint was submitted to the Director related to concerns with a resident's skin and wound care. On an identified date, a resident returned from the hospital and it was identified that they sustained three areas of altered skin integrity. A review of the resident's Electronic Treatment Administration Record (eTAR) for a three month period of time, revealed that the treatment was not provided by registered nursing staff to the resident on multiple occasions. There was no documentation on the resident's electronic progress notes to indicate the skin and wound treatment was provided.

Two staff members confirmed through their own record review that the skin and wound treatment was not provided as per order, on multiple shifts during the above mentioned time period. They indicated that it was not acceptable to miss the treatment for the resident as their skin condition was deteriorating.

Failure to provide the treatment as per the eTAR, put the resident at increased risk of skin deterioration.

Source: Clinical records, interviews with applicable staff.
[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (9) 1.

Non-compliance with: LTCHA, 2007,s. 6 (9) 1
The provision of care set out in the plan of care was not documented when a resident had altered skin integrity and required a specific intervention every two hours.

Rationale and summary
A complaint was submitted to the Director related to concerns with a resident's skin and wound care. On an identified date, a resident returned from hospital and it was identified that they sustained three areas of altered skin integrity. Their care plan was updated with a specific intervention every two hours, however there was no documentation in the resident's clinical records during a two month period that this intervention was provided.

A staff member was unable to confirm if the resident received the specific intervention as they could not find the documentation. They indicated that this intervention was not added in Point of Care (POC) software where the PSWs would document the care provided to resident. Two additional staff members indicated that the specific intervention for a resident with altered skin integrity was essential and by not documenting, they were not able to monitor the resident.

Failure to document the specific intervention of the resident caused confusion whether it was provided or not, and placed them at risk of skin deterioration.

Source: Clinical health records, interviews with applicable staff.
[741672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (i)

Non-compliance with: O.Reg. 79/10, s. 50 (2) (b) (i)
The licensee has failed to ensure that a clinically appropriate assessment tool that is specifically designed for skin and wound assessment, was used to assess a resident’s skin condition when they returned from hospital and exhibited altered skin integrity.

Rationale and summary
A complaint was submitted to the Director related to concerns with a resident's skin and wound care. The resident's clinical records indicated that when they returned from the hospital, they sustained three areas of altered skin integrity. However, the electronic skin and wound assessment tool in Point Click

Care (PCC) that registered nursing staff were required to use for skin and wound assessment, was not completed until up to two weeks later, when the affected areas deteriorated.

The home's Skin and Wound Care Management protocol indicated that "with a resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, the nurse will initiate and complete an electronic skin and wound assessment tool."

Two staff members confirmed that the skin and wound assessment tool that is designed for skin and wound assessment in PCC and used for residents' skin and wound assessment, was not completed upon the resident's return from the hospital. Failure to conduct a skin and wound assessment on the known altered skin integrity sustained by the resident, prevented the home from establishing a baseline of the areas, and potentially caused missed opportunities to monitor the resident's skin condition.

Source: Clinical health records, Skin and Wound Care Management protocol, interviews with applicable staff.

[741672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (ii)

Non-compliance with: O.Reg. 79/10, s. 50 (2) (b) (ii)
The licensee failed to ensure that a resident exhibiting altered skin integrity, received immediate treatment and interventions to prevent infection.

Rationale and summary
A complaint was submitted to the Director related to concerns of a resident's skin and wound care. On a specified date, it was recognized that the resident had altered skin integrity when they returned from the hospital, however no treatment was carried out until approximately two weeks after the area was identified.

The home's Skin and Wound Care Management protocol indicated that "with a resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, immediate treatment and interventions will be provided to reduce or relieve pain, promote healing, and prevent infection, as required."

Two staff members indicated that after identifying the altered skin integrity on the resident, treatment should have started to prevent further skin breakdown. By not providing immediate treatment for the resident's altered skin integrity, the resident was at increased risk of deterioration.

Source: Clinical health records, Skin and Wound Care Management protocol, interviews with applicable staff.
[741672]

WRITTEN NOTIFICATION: DRESS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44

Non-compliance with: O. Reg 246/ 22, s. 44
The licensee has failed to ensure that a resident was dressed appropriately, suitable to the time of day.

A written complaint was submitted to the Director and the LTCH related to concerns with a resident's clothing. The home's investigation notes revealed that the resident was changed to their pajamas in the early afternoon. When the family went in the home to visit the resident, they found the resident in pajamas which was not appropriate dress for that time of the day. As per the written complaint records, this incident had occurred on multiple occasions in the past and the resident's SDM had notified the home about their preference to be well dressed during the day and be changed to pajamas after supper.

A staff member confirmed that this incident had occurred in the past and the SDM had notified the staff about the resident's dressing preferences.

An additional staff member indicated that the expectation of the home is to change all residents to their pajamas after supper time unless a resident requested otherwise. They confirmed that the resident should not have been changed to their pajamas prior to supper specifically when it was not their preference.

Failure to dress the resident appropriately, suitable to the time of day was disrespectful to their dignity and bill of rights.

Source: Investigation notes, and written complaint.
[741672]

WRITTEN NOTIFICATION: FALL PREVENTION AND MANAGEMENT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

Non-compliance with: O. Reg 246/ 22, s. 54 (1)
The licensee has failed to ensure that the fall prevention equipment that was set out in the resident's plan of care was provided to the resident.

Rationale and Summary
The resident's care plan indicated that they were required to have fall prevention equipment in place at all times. Through observation of the resident, it was observed that the fall prevention equipment was not provided. A staff member indicated that the fall prevention equipment had not been provided by the home.

A staff member indicated that the resident had a history of multiple falls and fall related injuries in the past and all the fall prevention equipment should have been provided to the resident as indicated in the care plan.

Failure to provide fall prevention equipment to the resident as set out in their care plan may put them at risk of injury following any fall incident in future.

Sources: Care plan, interview with applicable staff, observation of the resident.
[741672]

WRITTEN NOTIFICATION: ACCOMODATION SERVICES

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (ii)

Non-compliance with: O. Reg 246/ 22, s. 95 (1) (a) (ii)
The licensee has failed to label a resident’s personal items and clothing in a dignified manner.

Rationale and summary
A written complaint was submitted to the Director and the LTCH related to concerns with the labeling of the resident's personal items and clothing. The complaint letter included a picture of the resident

wearing an article of clothing with their full name displayed in a large font on top of the article. As per the complaint letter, the resident's SDM had provided the article of clothing to a staff member and requested it to be labeled. The staff member had written the resident's name on top of the article of clothing without following home's labeling policy. The resident had worn the article of clothing with their name visible for approximately five days until their SDM visited and brought it to the home's management attention.

The home's Labelling of Clothing – Laundry Policy indicated that "Label clothing should be in a manner that respects resident dignity and does not damage clothing".

A staff member confirmed that they wrote the resident's full name on the article of clothing with a marker. They indicated that they did not refer to the home's labeling policy and did not ask the laundry staff prior to proceeding with labeling. Additional staff members indicated that the staff member should have either reviewed the labeling policy prior to proceeding with labeling or refer to the appropriate laundry staff for labeling as it was not acceptable that the resident's full name had been exposed.

Failure to label the resident's sneakers appropriately, impacted the resident's dignity and privacy.

Source: Labelling of Clothing – Laundry Policy, written complaint submitted to the home, interviews with applicable staff.
[741672]

COMPLIANCE ORDER CO #001 SKIN AND WOUND CARE

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg. 246/22, s. 55 (2)(b)(iv)

Specifically, the licensee must:
1.Review the contents of the compliance order with all registered nursing staff in the specified two home areas.
2. Conduct skin and wound assessment audits once weekly in the specified two home areas to ensure that registered nursing staff are completing the weekly skin and wound assessments for the residents who are exhibiting altered skin integrity. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented.

3. Review and re-train all registered nursing staff working in the two specified home areas on weekly skin and wound assessment. Maintain a written record of reviews and training provided to all registered nursing staff that includes who attended the training, the content, and the date training was completed.

Grounds
Non-compliance with s. 50 (2) (b) (iv) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 55 (2) (b) (iv) of O. Reg. 246/22 under the FLTCA.

The licensee has failed to ensure the resident's altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (iv) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55 (2) (b) (iv) of O. Reg. 246/22 under the FLTCA.

Grounds
i) A complaint was submitted to the Director related to concerns with a resident's skin and wound care. When a resident returned from hospital, it was recognized that they sustained three areas of altered skin integrity. The areas of altered skin integrity deteriorated over approximately three and a half months until the resident deceased. Review of the resident's medical records for a four month period of time, revealed that a consecutive weekly skin assessment had not been conducted for the affected areas using the home's skin and wound application.

Two staff members confirmed through their own record review that several weekly skin assessments were missing through the above mentioned time period.

Failure to conduct weekly skin assessments on the areas of altered skin integrity sustained by the resident prevented the home from monitoring the areas of altered skin integrity, implementing interventions and treatments at an earlier stage which resulted in deterioration of the skin condition.

Source: Clinical records, interviews with applicable staff.
[741672]

ii) A complaint was submitted to the Director related to concerns with a resident's skin and wound care. The resident's skin and wound assessments indicated that they had multiple areas of altered skin

integrity on their upper body during a five month period of time, however a consecutive weekly skin assessment had not been conducted.

A staff member confirmed through their own record review that several weekly skin assessments were missing after the areas of altered skin integrity were discovered.

Failure to conduct weekly skin assessments for the resident, prevented the home from monitoring the skin status which put resident at risk of deterioration of skin condition.

Source: Clinical records, interview with applicable staff.
[741672]

This order must be complied with by September 19, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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