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: January 9, 2023

Inspection Number: 2023-1389-0006

Inspection Type:
Complaint
Critical Incident

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Bradford Valley Community, Bradford

Lead Inspector	**Inspector Digital Signature**
Suzanna McCarthy (000745)	Suzanna McCarthy Digitally signed by Suzanna McCarthy Date: 2024.01.10 07:53:47 -05'00'

Additional Inspector(s)
Jennifer Brown (647)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 14, 18, 20, 2023
The inspection occurred offsite on the following date(s): December 15, 2023

The following intake(s) were inspected during this complaint inspection:

- One intake related to the neglect and abuse of a resident and a medication error.
- One intake related to abuse and neglect of a resident.

The following intakes were inspected during this Critical Incident (CI) inspection:

- One intake related to falls prevention and management
- One intake related to staff to resident physical abuse.
- One intake related to injuries of unknown cause for a resident.
- One intake related to resident to resident physical abuse.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Availability of Supplies

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

Non-compliance with: O. Reg. 246/22, s. 48

Availability of supplies

s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to ensure that there were sufficient supplies available for the operation of equipment related to prevention and management of falls.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long Term Care which identified that a resident had experienced a fall with injury. In the CIR, it was

noted that the resident was at high risk for falls and their care plan had been updated to reflect adjusted interventions to manage the falls risk for the resident.

During an observation, it was noted that one of the identified interventions was not present as required in the care plan. Registered staff reported that the resident was at an elevated risk of falls and that the prescribed interventions in the care plan were to be in place. The registered staff further reported that the reason the intervention was not in place at the time of the Inspector's observation was due to a shortage of supplies on the unit.

The Director of Care (DOC) also confirmed that the resident was at high risk of falls and that the interventions in the care plan had not been employed as directed.

Failure to have the required supplies to ensure that the resident's falls prevention tools were operational increased the risk that staff would not be notified should the resident attempt to self-transfer.

Sources: observations, resident's care plan, progress notes, s, interviews with staff. [000745]