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

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Original Public Report

Report Issue Date: September 20, 2023	
Inspection Number: 2023-1013-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Case Manor Care Community, Bobcaygeon	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21 to 25, 28 to 31 and September 1, 2023.
The inspection occurred offsite on the following date(s): September 5, 2023.

Intake: #00021494 -Follow up to CO #001, from inspection #2023_1013_0002 related to O. Reg. 246/22 s.102 (2) (b) issued on February 24, 2023, with CDD on April 6, 2023.
Intake: #00021496 - Follow up to CO #002, from inspection #2023_1013_0002 related to O. Reg. 246/22 s.93 (2) (b) (iii) issued on February 24, 2023, with CDD on May 19, 2023.
Intake: #00022228 - Complaint related to staff qualifications, abuse and unsafe storage of chemicals.
Intake: #00022895 and #00084134 -Two complainants related to residents rights, abuse and plan of care.
Intake: #00084034 (CI): related to staff to resident neglect.
Intake: #00084919 - (CI) and #00093097 (CI) related to staff to resident abuse.
Intake: #00086942 - (CI): related to resident to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1013-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Lynda Brown (111)

Order #002 from Inspection #2023-1013-0002 related to O. Reg. 246/22, s. 93 (2) (b) (iii) inspected by Lynda Brown (111)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure the plan of care for resident #010 provided clear direction for staff and others related to bathing, nail care, oral hygiene and falls.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director for an alleged staff to resident neglect. The CI indicated that the home received a written complaint from the family of resident #010 alleging neglect related to oral care, nail care and bathing.

Observation of resident #010 at various times, indicated the resident was well groomed. The resident had a number of fall prevention interventions in place, including the use of side rails.

Interview with the family confirmed their concerns of staff to resident neglect and continued to be a concern. The family indicated the staff reported the resident frequently refused their care. The family also indicated concerns related to falls and they had to request the use of side rails.

Interview with a PSW indicated they were aware of the residents bathing, oral and nail care needs. The PSW also identified specific strategies that were to be used to ensure the residents care needs were met when the resident was resistive or the staff were unable to complete the required care. The PSW also identified specified strategies related to the residents risk for falls. The PSW was unaware of the frequency of monitoring that was to be provided to the resident related to their risk of falls or the use of side rails.

The current plan of care had no clear direction related to bathing, no direction when the resident refused their baths and there was no direction provided regarding nail care. Under oral care, there was no direction related to how often oral care was to be provided, the status of the residents dentition, the use of a specified device or directions when the resident refused their oral hygiene. Under falls, there was no direction related to the use of side rails, despite side rails being in use and no direction related to placement of the resident while in bed.

Review of the documentation for PSWs, there was conflicting direction related to the frequency of monitoring of the resident. During a specified month, the resident had refused a number of baths and had refused oral care a number of times. There was no documentation related to nail care being provided.

Failing to ensure the plan of care for resident #010 provided clear direction related to bathing, nail care, oral hygiene and falls, placed the resident at risk for neglect.

Sources: CI, resident #010's health records, home's investigation records, and interview of the family and staff (ED and a PSW). [111]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that resident #001 had been reassessed, and the plan of care had been reviewed and revised, when their care needs changed or when the care set out in the plan was no longer necessary.

Rationale and Summary

Two complaints were received for resident #001 regarding resident's rights.

The resident was observed on multiple occasions over a two week period being provided access to outdoors without supervision. The resident's plan of care under responsive behaviours, provided conflicting information of the residents rights to access the outdoors independently.

The resident indicated they had not been afforded their right to access the outdoors independently for a number of months. The BSO staff, the acting DOC and the ED all indicated the resident was allowed to access outdoors with staff assistance only and was unsupervised. In addition, there was documentation a number of months prior from the Nurse Practitioner indicating the resident was able to have access to the outdoors independently but that access was never provided. The resident later indicated that they had now been provided full access to the outdoors and the plan had been revised as a result of the inspection.

Failing to ensure that the resident is reassessed, and the plan of care reviewed and revised for resident #001 prevented the resident's right to access the outdoors independently.

Sources: observations and review of the health record of resident #001, access card records, and interview of staff (RPN, acting DOC and ED). [111]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1.The licensee did not ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan related to responsive behaviours.

Rationale and Summary

A CI was submitted to the Director for a staff to resident abuse incident involving resident #002. The CI indicated the incident was witnessed and the resident had no injury.

Resident #002’s plan of care indicated when the resident demonstrated specified responsive behaviours,

staff were to utilize specified strategies. The home's investigation confirmed that the PSW was witnessed being abusive towards the resident and corrective actions were taken. The resident did not sustain any injury and could not recall the incident. The ED indicated that the PSW no longer worked at the home.

Failure to follow resident #002's plan of care resulted in a staff member becoming abusive towards the resident.

Sources: CI , resident #002's health record, home's investigation records, and interview of staff (ED). [111]

2.The licensee did not ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan related to responsive behaviours.

Rationale and Summary

A CI was submitted to the Director for a staff to resident abuse incident involving resident #007. The CI indicated the incident was witnessed and resulted in the resident sustaining a fall. The resident did not sustain any injury.

Resident #007's plan of care indicated the resident frequently demonstrated specified responsive behaviours and provided strategies to manage those behaviours. The home's investigation confirmed that a PSW had not followed the residents plan of care and was to receive retraining. Documentation revealed that the PSW completed the retraining as required.

Failure of a PSW to follow resident #007's plan of care resulted in the resident sustaining a fall.

Sources: CI, resident #007's health record, home's investigation records, and interview of staff (ED).[111]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

1.The licensee failed to ensure an alleged resident to resident abuse incident was immediately investigated.

Rationale and Summary

A CI was submitted to the Director for a resident to resident abuse incident. One of the residents sustained an injury and was upset regarding the incident. The other resident confirmed they had been involved in the incident. Both residents were cognitively impaired.

Interview with the ED and the ADOC both confirmed the previous DOC was involved in completing the investigation, but they were unable to locate any documentation related to the investigation.

Failing to have a documented investigation into a resident to resident physical abuse incident involving two residents leads to lack of actions being taken to prevent a recurrence.

Sources: CI, two residents health records, and interview with staff (ADOC and the ED). [111]

2.The licensee failed to ensure an alleged staff to resident #010 neglect allegation was immediately investigated.

Rationale and Summary

A CI was submitted to the Director for an allegation of staff to resident neglect involving resident #010. The resident was cognitively impaired.

Interview with the ED and the ADOC both confirmed the previous DOC was involved in completing the investigation, but they were unable to locate any documentation related to the investigation.

Failing to have a documented investigation into an allegation of staff to resident #010 neglect, leads to an incomplete investigation and lack of actions being taken to prevent a recurrence.

Sources: CI, resident #010's health records, and interview with staff (ADOC and the ED). [111]

WRITTEN NOTIFICATION: Reports of investigation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

1.The licensee failed to ensure a report of the results of every investigation and every action taken for a

staff to resident #002 abuse was provided to the Director.

Rationale and Summary

A CI was submitted to the Director for a staff to resident abuse incident involving resident #002. There was no documented evidence a report was provided to the Director of the results of the investigation and actions taken to prevent a recurrence upon completion.

Review of the home's investigation indicated the investigation had been concluded. Interview with the ED confirmed the investigation had been concluded and was determined to be founded with corrective actions taken. They confirmed the CI had not been updated to notify the Director of the results.

Failing to notify the Director of the results of resident #002's investigation for a witnessed staff to resident abuse leads to an incomplete investigation.

Sources: CI, resident #002's health record, home's investigation records, and interview of staff (ED). [111]

2.The licensee failed to ensure a report of the results of every investigation and every action taken for a staff to resident #007 abuse was provided to the Director.

Rationale and Summary

A CI was submitted to the Director for a staff to resident abuse incident involving resident #007. There was no documented evidence a report was provided to the Director of the results of the investigation and actions taken upon completion.

Review of the home's investigation indicated the investigation had been concluded. Interview with the ED confirmed the investigation had been concluded and the CI had not been updated to notify the Director of the results.

Failing to notify the Director of the results of resident #007's investigation for a witnessed staff to resident abuse leads to an incomplete investigation.

Sources: CI, resident #007's health record, home's investigation records, and interview of staff (ED). [111]

3.The licensee failed to ensure a report of the results of every investigation and every action taken for a

staff to resident #010 neglect was provided to the Director.

Rationale and Summary

A CI was submitted to the Director for an allegation of staff to resident neglect. The CI indicated the home received a written complaint letter from the family of resident #010 alleging staff to resident neglect. The resident was cognitively impaired.

Interview with the ED and the ADOC (#102) both confirmed the previous DOC was involved in completing the investigation, but they were unable to locate any documentation related to the investigation.

Failing to have a documented investigation into an allegation of staff to resident #010 neglect, leads to an incomplete investigation and lack of actions being taken to prevent a recurrence.

Sources: CI, resident #010's health records, and interview with staff (ADOC #102 and the ED). [111]

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

1.The licensee failed to ensure that resident #002's substitute decision-maker (SDM) was notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary

A CI was submitted to the Director for a witnessed staff to resident abuse incident involving resident #002. There was no documented evidence the SDM of resident #002 had been notified of the outcome of the investigation upon completion.

Interview with the Executive Director (ED) confirmed the investigation had been concluded and was determined to be founded. They confirmed the SDM had not been immediately notified of the outcome.

Failing to notify the SDM of resident #002 of the outcome of the home's investigation into witnessed staff to resident physical abuse leads to mistrust.

Sources: CI , resident #002's health record, home's investigation records, and interview of staff (ED). [111]

2.The licensee failed to ensure that resident #007's SDM was notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary

A CI was submitted to the Director for a witnessed staff to resident abuse incident involving resident #007. There was no documented evidence the SDM of resident #007 had been notified of the outcome of the investigation upon completion.

The home's investigation had been concluded but no indication of the outcome of the investigation. Interview with the ED indicated the investigation had been completed by the previous DOC. They confirmed the SDM had not been notified of the outcome.

Failing to notify the SDM of resident #007 of the outcome of the home's investigation into witnessed staff to resident abuse leads to mistrust.

Sources: CI, resident #007's health record, home's investigation records, and interview of staff (ED). [111]

3.The licensee failed to ensure that resident #010's SDMs were notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary

A CI was submitted to the Director for a staff to resident neglect incident. The CI indicated the home received a written complaint letter from the family of resident #010 alleging neglect. A written response was provided to the family indicating what the home had done to ensure care was provided to the resident but there was no indication of the outcome of the investigation upon completion.

Interview of the family of resident #010 confirmed they had not been provided the outcome of the home's investigation. Interview with ADOC #102 and the ED indicated the investigation had been completed by the previous DOC and they were unable to locate an investigation.

Failing to notify the SDM of resident #010 of the outcome of the home's investigation into alleged staff to resident #010 neglect leads to mistrust.

Sources: CI, resident #010's health records, and interview with staff (ADOC #102 and the ED). [111]

WRITTEN NOTIFICATION: Exceptions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 254 (4)

The licensee failed to ensure that a staff member that was hired during a pandemic and no police record check was provided to the licensee, the licensee ensured that a police record check was provided to the licensee within three months after the staff member was hired and kept the results of the record check.

Rationale and Summary

A complaint was received regarding the home hiring staff during the pandemic, providing care to residents that were not qualified.

Review of staff records for a number of PSW's indicated they were hired full-time during the pandemic as PSW's. There was no documented record of a police record check completed for any of the PSW's. Some of the PSW's no longer worked in the home.

Interview with staff #103 indicated they were involved with the onboarding of the new staff, confirmed they were hired as PSW's and there was no police record check on file for any of the identified staff. The acting Director of Care and the Executive Director were not aware that there was no police record check completed for any of the identified staff hired as PSW's.

Failing to ensure a police record check was provided to the home for staff working as PSW's and providing care to residents, places the residents at risk.

Sources: employee records of PSW's and interview of staff (staff #103, Acting DOC and the ED). [111]