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
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Oshawa, ON, L1H 1A1
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Public Report

Report Issue Date: March 11, 2025
Inspection Number: 2025-1013-0001
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Case Manor Community, Bobcaygeon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26 -28, 2025 and March 4 -7, 2025

The following intake(s) were inspected:
- An intake regarding resident-to-resident physical abuse.
- An intake regarding neglect of residents.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff and others involved in the various aspects of care for a resident collaborated in the development and implementation of the care plan. This failure meant that the different aspects of care were not integrated, consistent, or complementary.

A critical incident report (CIR) was submitted to the Director concerning alleged physical abuse by a resident towards their roommate, resulting in an injury.

Prior to the reported CIR, the alleged abuser had several reports of unmanaged responsive behaviours towards their previous roommate. The previous roommate was moved to a different room. During this time, no responsive behaviour assessments were completed for the alleged abuser related to these incidents. The long-term care home move a new co-resident into the alleged abuser's room the following day.

The physical altercation reported to the Director resulted in an injury to co-resident. After the incident, the alleged abuser was observed with co-resident's belongings. Another incident was reported 10 days later, where the alleged abuser was witnessed physically hitting co-resident.

During a two month record review, the alleged abuser had eight incidents involving their roommates. There was no indication of an integrated assessment or reassessments in the development and implementation of the resident's care plan.

Sources: CIR, residents clinical records, and interview with staff.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

1. The licensee failed to ensure that the outcomes set out in the resident's plan of care were documented.

A CIR was submitted to the Director regarding the alleged physical abuse of a resident by a resident.

Following the incident between residents, a Registered Nurse implemented 15-minute safety checks. However, there was no documentation indicating who completed the checks, when they were completed, how long they were in place, or if they were completed.

Sources: CIR, residents clinical health records, and interview with staff.

2. The licensee failed to ensure that the outcomes of daily care, as set out in the plan of care, were documented for residents.

A CIR was submitted to the Director regarding allegations of neglect of residents. In the report, the long-term action plan included that the Director of Care/Assistant Director of Care would monitor the care records and documentation daily and correct any deficiencies as soon as possible.

During a review of the daily care records for two residents that were mentioned in

the allegations of neglect, it was found that several shifts had no documentation of the outcomes or whether care was provided to the residents. These deficiencies were not corrected.

Sources: CIR, residents clinical health records and interview with staff.

3. The licensee failed to ensure that the outcomes of the care set out in the plan of care was documented related to continence care.

A CIR was submitted to the Director related to alleged neglect of residents. During the LTC home's investigation, a resident voiced concerns related to waiting for continence care. During a record review, a resident's care records only indicated one continence occurrence. Additional resident records were reviewed, which records also indicated one outcome of continence care per shift.

Sources: CIR, LTC home's investigation, resident's clinical care records and interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

1. The licensee failed to protect a resident from physical abuse by a resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)

A CIR was submitted to the Director concerning alleged physical abuse by a resident towards a co-resident, which resulted in an injury.

The long-term care moved a co-resident into a resident’s room after several altercations occurred with a previous roommate. There were no steps taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions prior to moving another co-resident into the alleged abuser's room.

The resident admission's clinical records indicated co-resident had a potential responsive behaviours as well. There were no interventions in place to manage this and reduce risk when moving the co-resident in with the resident that has a history of altercation with their roommate.

An altercation with the alleged abuser and the resident was witnessed , resulting in the resident's sustaining an injury.

The following non-compliances were identify contributing to the failure of protecting the resident:

Written notification, FLTCA, 2021 s. 6 (4) (b) Integration of assessments, care
Written notification, O. Reg. 246/22 s. 58 (1) 1. Responsive behaviours
Written notification, O. Reg. 246/22 s. 59 (b) Altercations and other interactions between residents

Sources: CIR, resident's clinical records, and interview with staff.

2. The licensee failed to protect residents by ensuring they are not neglected by

licensee or staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIR was submitted to the Director related to alleged neglect towards residents, including not receiving consistent care and baths.

The investigation notes included staff confirming that baths were not being done consistently, and by evidence of resident's dirty hair and unclean fingernails. During a record review of three residents, there were blanks in the resident care records, not indicating if care was provided to the residents on several occasions.

The ADOC - RN confirmed these further allegations were not investigated.

Sources: CIR, residents clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to immediately report alleged improper or incompetent

treatment or care of a resident that resulted in a risk of harm.

A CIR was submitted to the Director related to neglect of residents. During the long-term care home's investigation, they spoke with a resident regarding their care. The resident expressed concerns regarding the time waiting to receive continence care and that staff are too busy to be careful during care.

The resident indicated to Inspector that they experienced pain, during care. They indicated one staff member on the Night Shift comes into their room, who speaks very mean towards them and causes them more physical pain than usual during care.

The ADOC - RN confirmed these concerns were not reported to the Director or investigated.

Sources: CIR, interview with resident and staff.

WRITTEN NOTIFICATION: Foot care and nail care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of finger nails. by not having a means of documenting of outcome of care provided.

Resident was observed having long nails with dark material under their nails.

The resident's clinical records did not indicate when their fingernail care was last

performed.

A Personal Support Worker indicated there was no location on the electronic care records to document when or what fingernail care was provided.

Sources: Observations, resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interaction between a resident and other residents, including identifying and implementing interventions.

A CIR was submitted to the Director regarding the alleged physical abuse of a co-resident by a resident.

Prior to the CIR, the resident had several reports of responsive behaviours towards a roommate. There were no indication of steps taken to minimize the risk of altercations by identifying and implementing intervention prior to moving a resident experiencing responsive behaviour altercations.

Sources: CIR, resident clinical health records and interview with staff.

WRITTEN NOTIFICATION: Police notification

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service was immediately notified of any alleged, suspected, or witnessed incident of abuse involving a resident, which the licensee suspects may constitute a criminal offence.

A CIR was submitted to the Director regarding an alleged incident of resident-to-resident physical abuse. A resident sustained an injury during an altercation with co-resident. The police were not notified.

Sources: CIR, residents clinical health records, interview with staff.

COMPLIANCE ORDER CO #001 Licensee must investigate, respond and act

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(ii) neglect of a resident by the licensee or staff, or

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure:

1. Provide training to the DOC, ADOC-RN, and ADOC-IPAC on how to complete an investigation and when an investigation is to be completed. Ensure training records include who provided the training and when the training was completed.
2. Complete a thorough investigation into the alleged neglect reported to the Director immediately, including the allegations of baths not being completed as per the residents' plans of care. Maintain all investigation notes.
3. Ensure staff are able to document the outcomes of care provided, including whether a resident received a bath, shower, or bed bath.
4. Audit baths for 4 weeks on the first floor, for all shifts, ensuring the residents are receiving a bath and as per their preference of bathing.
5. Provide all documentation upon the Inspector's request.

Grounds

The licensee failed to ensure that every alleged, suspected, or witnessed incident of neglect of a resident, known to the licensee or reported to the licensee, was immediately investigated.

An allegation of neglect was brought forward to the long-term care home, specifically indicating that day staff were not consistently providing care to residents. The allegation included that three residents were not receiving care and that resident's were going without baths. It was also indicated that Registered Nursing staff were aware of these concerns but were not addressing them.

The long-term care home's investigation included interviews with staff. Three staff

members confirmed that residents were not consistently receiving baths and appeared unclean, with dirty hair and nails. However, these allegations were not thoroughly investigated.
The investigation did not include interviews with the Registered Nurses or the evening staff.

The CIR to the Director indicated that the allegations were unfounded, despite staff confirming the concerns brought forward.

By not immediately investigating, responding and acting on alleged neglect of the residents, put these residents at risk of physical, emotional and/or mental harm that would have impact on their well-being.

Sources: CIR, the LTC home's investigation notes, and interview with staff.

This order must be complied with by May 16, 2025

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure:

1. The BSO Lead and ADOC-RN will complete a clinical review of residents. Identify any past, resolved, and/or current responsive behaviours.
2. The BSO Lead will complete the assessments as indicated in the policy for indicated residents, including the PIECES assessment. The BSO team will maintain a record of any information gathered from documents, staff, and family to complete the PIECES assessment in the clinical records. Retain the documentation for the Inspector to review.
3. The BSO team will update the written plan of care for the residents. The plan of care will identify any possible responsive behaviours, triggers, and interventions for staff to manage. The BSO team will document unsuccessful interventions and the dates they were trialed. Retain the documentation for the Inspector to review.
4. The plan of care for the residents will be communicated shift-to-shift to ensure the direct care staff are aware. Documentation on how, when, and to whom this information was communicated to must be retained.

Grounds

1. The licensee failed to comply with the home's Responsive Behaviour Management policy when the staff did not complete a referral and clinically indicated behavioural assessments for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Responsive Behaviour Management program are complied with. Specifically, the home’s Responsive Behaviour Management policy indicates that staff shall complete an electronic Responsive Behaviour Assessment & Referral to the internal Behavioural Support Lead/Designate when there is a new, worsening, or change in responsive behaviors, or upon the move-in of a resident with identified responsive behaviors that pose a risk. Additionally, the Behavioural Support Team will offer a combination of direct

care, clinical assessments, and care planning services, as well as support and education to reduce and/or prevent responsive behaviors.

A CIR was submitted to the Director regarding alleged physical abuse by a resident towards their roommate, resulting in an injury.

A co-resident moved into the long- term care home with potential responsive behaviours, that were indicated on their admission clinical records. No referral or assessments were completed to mitigate risk prior to moving them in with the resident that had a history of altercations with roommate. No assessments, reassessments, or interventions were in place to reduce or help manage the resident's responsive behaviours.

By not completing the appropriate assessments for the resident when clinically indicated on admission, the licensee put the resident at risk of harm from other residents. The impact of unmanaged responsive behaviours continues to put the resident at risk of harm.

Sources: CIR, resident clinical records, and interviews with staff.

2. The licensee failed to comply with the home's Responsive Behaviour Management policy when the staff did not complete a referral and clinically indicated behavioural assessment for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Responsive Behaviour Management program are complied with. Specifically, the home’s Responsive Behaviour Management policy indicates that staff shall complete an electronic Responsive Behaviour Assessment & Referral to the internal Behavioural Support Lead/Designate when there is a new, worsening, or change in responsive behaviors, or upon the move-in of a resident with identified responsive behaviors that pose a

risk. Additionally, the Behavioural Support Team will offer a combination of direct care, clinical assessments, and care planning services, as well as support and education to reduce and/or prevent responsive behaviors.

A CIR submitted to the Director regarding alleged physical abuse by a resident towards their roommate, resulting in an injury.

Resident's clinical records indicated altercations with a previous roommate. No referral was sent to the Behavioural Supports Team, and no further assessments related to the resident's new or worsening behaviours were completed. A another resident was moved into the resident's room. Shortly after the residents had an altercation resulting in an injury. The LTC home did not send a referral to the BSO Team, and no behavioral assessments were completed as indicated in the licensee's policy.

By not completing the appropriate assessments for the resident when clinically indicated in the licensee's policy, including on admission and with new or worsening behaviours, the licensee put co-residents at risk of harm from the resident. The impact of unresolved and unmanaged responsive behaviours resulted in eight altercations in two months.

Sources: CIR, resident's clinical health records, and interviews with staff.

This order must be complied with by May 16, 2025

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.