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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 20, 2024

Inspection Number: 2024-1307-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Royale Development LP by its general partner, The Royale Development GP Corporation

Long Term Care Home and City: Woods Park Community & Retirement Living, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26-29 and December 2-6 and 9, 2024
The following intake(s) were inspected:

- Intake: #0012554 related to injury of unknown cause.
- Intake: #00125709 related to fall of resident resulting in injury
- Intake: #00125918 related to physical altercation between residents.
- Intake: #00126195 related to physical altercation between residents.
- Intake: #00128051 related to complainant alleges improper care of residents.
- Intake: #00129650 related to ARI unknown outbreak.
- Intake: #00130460 related to verbal and emotional abuse of resident by staff.

The following intakes were completed:

- 00125432 related to falls prevention and management.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and 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)
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under the falls prevention and management program, including an intervention, was documented.

Rationale and Summary
Resident was at risk for falls and the implemented intervention was not documented in the resident's written plan of care and kardex.

The ADOC documented the intervention in the resident's written plan of care.

Sources: Resident's clinical health records; Interviews with the ADOC, and other staff.

Date Remedy Implemented: November 29, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure that a residents right of privacy in caring for their personal needs was fully respected and promoted.

Rationale and Summary
Personal Support Worker (PSW) assisted a resident out from the shower room to their room in a manner that did not promote their privacy.

By not affording privacy to the resident in caring for their personal needs placed the resident's privacy was comprised.

Sources: Resident clinical records, LTCH's investigation notes and photo and interviews with resident, staff, DOC and ED.

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.

The licensee failed to protect resident #007 from verbal abuse by staff.

Rationale and Summary
According to O. Reg 246/22, verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The PSW yelled, used inappropriate and abusive language towards the resident while transferring them to the chair.

Failure to protect the resident from verbal abuse emotionally impacted the resident.

Sources: Resident's clinical record, LTCH's investigation notes and interviews with resident, staff and DOC.

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) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of resident #003 that resulted in harm or a risk of harm to the resident

had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Residents #002 and #003 had a verbal and physical altercation and resident #003 sustained injuries.

This incident was reported to the Director of the Ministry of Long Term Care (MLTC) one day later.

Failure to immediately report abuse of a resident to the Director may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CI #2821-000020-24, Resident #003's clinical health records; Interviews with ADOC, and other staff.

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee failed to ensure that each resident of the home has the desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Rationale and Summary
The MLTC received a complaint that night shift staff were providing personal care to residents daily between 0400 hours and 0600 hours including full body wash, these residents were dressed in day clothes and were left in bed ready for the day shift.

The PSW stated when they worked night shift they start providing personal care to four residents around 0400 hours or 0430 hours and also said some residents were awake and sometimes they would wake them up to provide a full body wash and to dress them up in day clothes for the day shift.

The Executive Director (ED) said that night shift staff should not provide complete personal care before 0600 hours.

Sources: Residents clinical records, interviews with PSWs, RPN, DOC and ED.

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 interactions between two residents including identifying and implementing interventions.

Rationale and Summary
Two residents had a verbal and physical altercation and one of the residents sustained injuries as a result of this incident.

Despite previous altercations between these two residents there were no interventions that were developed and implemented to minimize the risk of altercations and potentially harmful interactions.

By not identifying and implementing interventions, altercations recurred between these two residents.

Sources: Residents clinical health records; Interviews with BSO Assistant, ADOCs and other staff.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that procedures and interventions were developed and implemented to assist staff who were at risk of harm or who were harmed as a result of a resident's responsive behaviours.

Rationale and Summary
A review of a resident's behavioural progress notes indicated inappropriate behaviours towards staff.

The resident's written plan of care did not include any information including procedures and interventions for their inappropriate responsive behaviours.

By not developing and implementing procedures and interventions places staff at risk of harm.

Sources: Resident's clinical health records; Interviews with BSO Assistant, ADOCs and other staff.

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee failed to ensure that cleaning and disinfection was in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018, indicated that there should be systems in place to ensure the efficacy of disinfectants over time, such as a review of the expiry date.

Housekeeper (HK) indicated to the Inspector that they used Saber and Oxivir TB disinfectants to clean and disinfect high touch surfaces. The HK showed the bottles of disinfectants to the Inspector, and it was noted that the Oxivir TB's and the Saber's were expired.

When the home failed to ensure that a process was in place to prevent expired disinfectants from being used in the home, there was a risk that contact surfaces were not effectively cleaned and disinfected.

Sources: Inspector's observations; PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018, the home's policies and procedures; Interviews with the IPAC Lead, and other staff.

WRITTEN NOTIFICATION: Licensee to retain records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 312 (d)
Licensee to retain records
s. 312. For the purposes of section 95 of the Act, every licensee of a long-term care home shall keep, for each long-term care home operated by the licensee,
(d) any agreement between the Minister and the licensee for funding provided under section 93 of the Act and any service accountability agreement required by section 22 of the Connecting Care Act, 2019, the records and reports required under those agreements and the records used to produce those records and reports;

The licensee failed to produce records and reports required under agreement between the Minister and the licensee for funding provided under section 93 of the Act and any service accountability agreement required by section 22 of the Connecting Care Act, 2019.

Rationale and Summary
A complaint was received that the Registered Practical Nurses (RPN) working in the LTCH area were going to the Retirement Home (RH) area located in the same building to attend to residents for medical emergencies or palliative care services.

The RPN stated they attend the residents in the RH area for several reasons including falls incident, other medical emergencies and residents receiving palliative care services who require support. The RH area does not have their own nursing staff and rely on the RPN from the LTC section to provide those services.

The Executive Director stated they did not have a process to maintain records or to track how much time RPNs from the LTC home were are spending in the RH to provide care to those residents.

Sources: Email from ED including falls incidents record and Interview with ED and RPN.

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1. Provide re-education to PSW #104 and PSW Student #107, specific to the use of PPE when providing direct care to residents who are on contact precautions.

2. Provide re-education to PSWs #105, #106, and RPN #113 related to the four moments of hand hygiene, including but not limited to before initial resident environment contact, after resident environment contact, before donning gloves, after doffing gloves, and before handling food or drink.

3. Provide re-education to PSW #105 related to the home's Point of Care Risk Assessment policy, specific to maintaining donning and doffing steps when using PPE.

4. Maintain records of items #1 to #3 including the dates, facilitator, staff names and designation, signed attendance, content of education and training materials.

5. Complete PPE audits daily for a period of two weeks to ensure that:
-PSW #104 and PSW Student #107 are in compliance with the home's contact precautions policy, when providing direct care to residents who are on contact precautions.
-PSW #105 is in compliance with the Point of Care Risk Assessment policy, specifically, maintaining donning and doffing steps when using PPE with resident care.

6. Complete hand hygiene audits daily for a period of two weeks, to ensure that PSWs #105, #106, and RPN #113 are in compliance with the home's hand hygiene program.

7. Maintain records of items #5 and #6 including the auditor, the dates and times of the audits, the staff audited, results and analysis of the audits, and actions taken.

Grounds
The licensee failed to ensure that the standard issued by the Director with respect to IPAC, was implemented.

Rationale and Summary
According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

A) The IPAC Standard for LTCHs, revised in September 2023, section 9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include: b) 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).

The home's Hand Hygiene policy indicated that hand hygiene consists of either hand washing or the use of alcohol-based hand rub (ABHR), and all team members will practice hand hygiene according to the four moments of hand hygiene, including but not limited to before initial resident environment contact, after resident environment contact, before donning gloves, after doffing gloves, before handling food or drink.

Observations were conducted by the LTCH Inspector and observed that PSWs #105, #106, and RPN #113 did not practice hand hygiene according to the four moments of hand hygiene, including before initial resident environment contact, after resident environment contact, before donning gloves, after doffing gloves, and before handling food or drink.

Sources: The home's Hand Hygiene policy #IX-G-10.10 last revised March 2024; Inspector's observations and the home's video surveillance; Interviews with the IPAC Lead, SED, and other staff.

B) The IPAC Standard for LTCHs, revised in September 2023, section 5.3 (c) indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to contact transmission and precautions.

The home's Contact Precautions Team Members-Residents-Visitors policy indicated that team members will wear appropriate PPE for all interactions that may involve contact with the resident/ resident environment. Gloves will be worn if direct contact will occur, and gowns will be worn if direct contact with a resident is required or if contamination or soiling is likely.

Resident was on contact precautions.

The PSW #104 and a PSW student participated in the provision of resident's direct care in their room. The PSW and PSW student did not don appropriate PPE prior to

entering the resident's room and when they participated in the resident's care.

Sources: Resident's clinical health records, Contact Precautions Team Members-Residents-Visitors policy #IX-G-10.70(a) dated March 2024; Inspector's observations and the home's video surveillance; Interviews with the IPAC Lead, SED, and other staff.

C) The IPAC Standard for LTCHs, revised in September 2023, section 5.3 (a) indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to Point of Care Risk Assessments.

The home's Point of Care Risk Assessment policy indicated that all team members will maintain donning and doffing steps when using PPE.

Observations were conducted by the LTCH Inspector and observed that the PSW did not adhere to the recommended steps for donning and doffing of PPE.

By not adhering to the home's IPAC policies and procedures related to hand hygiene, contact precautions, and point of care risk assessment, there was an increased risk for the spread of infectious microorganisms amongst the residents and staff members.

Sources: The home's Point of Care Risk Assessment policy #IX-G-10.12 last revised April 2024, Recommended Steps for Putting On & Taking Off PPE policy #IX-G-10.20(a); Inspector #653's observations and the home's video surveillance; Interviews with the IPAC Lead, SED, and other staff.

This order must be complied with by January 30, 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.