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

Original Public Report

Report Issue Date: September 17, 2024
Inspection Number: 2024-1412-0003
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: Woodhall Park Community, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27 - 30, September 3 - 6, and 9 - 10, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00117093 and Intake: #00117094 related to allegations of resident abuse
- Intake: #00120372 related to unknown origin of injury to resident

The following intake(s) were inspected in this Complaint inspection:

- Intake: #00120980, concerns related to improper care of residents

- Intake: #00121040, concerns related to lack of care and medication management for a resident
- Intake: #00121738, concerns related to financial abuse to a resident

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided assistance as per their plan of care.

Rationale and Summary
An incident occurred where a resident was not provided a bath in the method

specified in their plan of care. During the inspection it was also observed that on two occasions the residents fall prevention interventions were not in place as stated in their plan of care.

The Assistant Director of Care (ADOC) verified that it was an expectation for all staff to follow interventions that were outlined in the care plan pertaining to bathing and bed safety.

When the home failed to implement the interventions specified in the resident's plan of care, the resident may not have received the care they required.

Sources: Care plan, documentation survey report, observations during inspection, interviews with PSWs, and ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure the home complied with their written policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
A) The home submitted a critical incident (CI) report to the Ministry of Long-Term

Care (MLTC) related to an allegation of abuse toward a resident.

The home did not interview the staff member who provided direct care and assistance to the resident.

The home's Prevention of Abuse & Neglect of a Resident policy from October 2023, stated that the Executive Director (ED) or designate would initiate an investigation and interview any person that may have knowledge of the situation.

Sources: review of the home's investigation notes, and the home's Prevention of Abuse & Neglect of a Resident policy from October 2023, interview with ADOC.

B) A CI was submitted to the Director related to an allegation of physical abuse toward a resident.

The home's investigation notes indicated that the complainant was not interviewed as part of the home's investigation.

According to the home's Prevention of Abuse & Neglect of a Resident policy from October 2023, the Executive Director (ED) or designate investigator should interview any person that may have knowledge of the situation.

ADOC confirmed that the home did not interview the witness as part of the home's investigation.

Failure to follow the home's policy to promote zero tolerance of abuse and neglect of residents, by not interviewing the witness may have contributed to the home's inability to substantiate the abuse allegations.

Sources: Home's Prevention of Abuse & Neglect of a Resident policy from October 2023, the home's investigation notes, and interview with ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 immediately report to the Director the suspicion of abuse that resulted in harm to residents.

Pursuant to s. 154 (3), the licensee was vicariously liable for staff members failing to comply with subsection 28 (1).

Rational and Summary
A) A resident sustained an injury where a staff member assessed the resident and should have reported their suspicion of abuse to the Director.

The incident was not reported to the MLTC until the family filed a complaint with the home.

By not reporting immediately to the Director the home's suspicion of abuse that resulted in harm to the resident, limited the Director's ability to respond to the

incident.

Sources: Review of CI report and interview with ADOC.

B) A staff member allegedly witnessed an incident of staff to resident abuse. The incident was not reported to the Director until three days later.

By not immediately reporting the suspicion of alleged abuse of a resident, the Director was unable to respond immediately.

Sources: CI reports and ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that when a resident had an injury, that they received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

Summary and Rationale
A staff member reported during morning care to a registered staff that the resident

was observed to have an injury.

Registered staff did not assess or provide treatment to the injury until seven hours later.

When the area of the injury was not assessed and treated immediately, this may have contributed to the worsening of the area that day.

Sources: review of the home's skin and wound assessments. Home's investigation notes, interviews with PSW, registered staff and ADOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
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:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that the staff implemented the written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Rationale and Summary
A resident exhibited responsive behaviors when being provided care. Staff did not follow interventions for the resident according to the homes practices.

The ADOC confirmed that the strategies used by staff did not align with a Gentle Persuasive Approaches (GPA) intervention.

Failure to follow the written strategies including techniques and interventions for responsive behaviour for the resident put other residents at risk for potential injury.

Sources: Resident's care plan, interviews with ADOC, registered staff, PSW, and other staff

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident's consulting physician recommended a prescribed medication with a sliding scale dosage daily to aid in the management of the resident's responsive behaviours.

A registered staff transcribed the order on the Physician's order sheet and sent it to the pharmacy without clarifying the dose and directions for use with the Physician.

The pharmacist changed the dosing administration without notifying the prescribing Physician or the resident's primary Physician. The resident later had an adverse reaction to the medication.

The home's attending Physician said the prescribed medication should have been started and administered at the lowest recommended dose.

Not following the prescriber's directions for use of prescribed medication increased the resident's risk for adverse drug effects and may have contributed to the resident's deterioration in their health condition.

Sources: resident's clinical records and interviews with two registered staff, ADOC, Pharmacist, physician and other staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that an adverse drug reaction involving a resident was reported to the prescriber of the drug, and the pharmacy provider.

Rationale and Summary

A resident had an adverse reaction after being administered a prescribed medication and had an adverse reaction to a newly prescribed medication.

The prescriber of the drug, and the pharmacy provider were not informed about the adverse reaction to the medication until two months later when the Long-Term Care Homes (LTCH) inspector had a discussion with the home.

By not informing the prescriber of the drug, and the pharmacy provider of the adverse reaction it limited their ability to take the appropriate action to prevent that the medication would be prescribed in the future.

Sources: resident progress notes, electronic medication administration record (eMAR), the hospital records, adverse drug reaction policy (July 2024) and interviews with the ADOC physician, and Pharmacists.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,

(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee has failed to ensure that a resident incident of adverse drug reaction was reviewed and analyzed.

Rationale and Summary
A resident had an adverse drug reaction a to a prescribed medication. The home's ADOC stated that the home did not initiate a review and analysis of the incident as required.

By not reviewing and analyzing the incident of adverse drug reaction increased the risk that appropriate interventions might not be implemented to protect the resident from future negative outcomes.

Sources: residents clinical records and interviews with ADOC, Pharmacists and the physician.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (c)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a record of an adverse drug reaction involving a resident was kept at the home.

Rationale and Summary
A resident had an adverse reaction to a prescribed medication and the home was not able to provide a written record of the adverse reaction incident report.

By not keeping a record of the adverse reaction incident report increased the risk that the incident may not be analyzed and reviewed to ensure appropriate actions were implemented, if required.

Sources: residents clinical records, hospital records and an interview with ADOC.