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: November 16, 2022	
Inspection Number: 2022-1477-0001	
Inspection Type: Complaint and Follow up	
Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)	
Long Term Care Home and City: Royal Rose Place, Welland	
Lead Inspector Lisa Vink (168)	**Inspector Digital Signature** Lisa Vink Digitally signed by Lisa Vink Date: 2022.11.25 18:53:48 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 11, 12, 13, 14, 17, 18, 19, 24, 25, 26, 27, 28, 31 and November 1, 2 and 3, 2022.

The following intake(s) were inspected:

- Intake: #00001748 - an anonymous complaint related to multiple concerns.
- Intake: #00004425 - an anonymous complaint related to multiple concerns.
- Intake: #00004733 - Follow-Up to Compliance Order #001 from Inspection Report #2022_991214_0005, regarding Ontario Regulation 79/10, section 8. (1), with a compliance due date of May 05, 2022.

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

Safe and Secure Home
Housekeeping, Laundry and Maintenance Services
Medication Management
Residents' Rights and Choices
Food, Nutrition and Hydration
Resident Care and Support Services
Continence Care
Prevention of Abuse and Neglect

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 #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rational and Summary
The plan of care for a resident identified a specific fluid goal to maintain adequate nutrition and hydration with their individualized calculated fluid needs.
An intervention in the plan included a different quantity of fluids as their goal at meals.
The Registered Dietitian (RD) reviewed and revised the resident's plan of care to provided clear direction to staff and others who provided care to the resident when they edited the record for their calculated fluids needs.

Sources: Review of the plan of care for a resident and interview with staff. [168]

Date Remedy Implemented: November 3, 2022.

WRITTEN NOTIFICATION: Duty to protect

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that they protected a resident from abuse by anyone.

Rational and Summary
Ontario Regulation 246/22 section 2. (1) identified for the purpose of a definition of "abuse" in subsection 2 (1) of the Act, emotional abuse was any threatening or intimidating gestures, actions, behaviour or remarks by a resident that caused alarm or fear to another resident where the resident

who performed the gestures, actions, behaviour or remarks understood and appreciated their consequences.

Resident #002's progress notes identified that resident #001 made a comment which upset resident #002.
Staff present during the interaction reported that in their opinion resident #002 had a negative response to the comment.
Resident #002 reported how the comment made them feel.
Failure to protect resident #002 from abuse resulted in a response from the resident.

Sources: Progress notes of residents and interviews with a resident and staff. [168]

WRITTEN NOTIFICATION: Laundry services

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 95 (1) (a) (iv)

The licensee has failed to ensure that as part of the organized program of laundry services under clause 19 (1) (b) of the Act, they had procedures implemented to ensure that, there was a process to report and locate residents' lost clothing and personal items.

Rational and Summary
The home had a procedure titled Lost Clothing which identified steps to be taken when a missing item was reported.
The procedure was not revised with the implementation of the Lost and Found Binder.
The Housekeeping/Laundry Supervisor indicated after the third floor of the home opened there was an increase in found items, those without labels and staff were not able to identify the owner, at which time a Lost and Found Binder was developed.
The binder was located in the main lobby, included photographs and a description of all found items.
The Lost Clothing procedure did not include the Lost and Found Binder.
A staff member reported that they would look in the laundry for missing items, without mention of the binder.
Residents interviewed were not aware of the Lost and Found Binder.
Failure to ensure that the updated procedure was implemented had the potential for staff to be unaware of the entire process available to locate lost items.

Sources: Review of Lost Clothing procedure and Lost and Found Binder and interviews with staff and residents. [168]

WRITTEN NOTIFICATION: Availability of supplies

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 48

The licensee has failed to ensure that a supply was readily available at the home to meet the nursing and personal care needs of residents.

Rational and Summary
Three residents were identified to require a specific item to meet their care needs
The item was not consistently readily available, including during the time of the inspection, as confirmed by the residents, staff, a family member and observations.
Staff reported that a family member provided the item for the resident's use.
Failure to ensure that the item was readily available resulted in an increased cost to a resident and family and potential discomfort for residents.

Sources: Interviews and observations with residents and staff.[168]

WRITTEN NOTIFICATION: Plan of care

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed, and the plan of care revised when the care set out in the plan was not effective.

Rational and Summary
A resident had a plan of care which included care needs and interventions related to a responsive behaviour.
A review of the progress notes identified the resident had made comments to staff and a co-resident.
On review of the plan of care, it was not revised to include in the focus statement for the behaviour, the resident's comments nor any interventions to manage the situation.
Failure to ensure that the plan of care was revised when the care set out in the plan was ineffective had

the potential for staff to be unaware of the additional needs of the resident, inconsistent interventions and potential harm to the co-resident.

Sources: Progress notes and plan of care for a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: Housekeeping

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (a) (i)

The licensee has failed to comply with the housekeeping program, related to the daily cleaning of resident bedrooms, including floors and wall surfaces.

In accordance with O. Reg. 246/22 s. 11 (1) b the licensee was required to have an organized program of housekeeping which included that procedures were developed and implemented for the cleaning of resident bedrooms including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces and that the procedures were complied with.

Rational and Summary
The home's Cleaning Procedure: Bedrooms – Daily, directed staff to follow the Daily Cleaning of Resident Rooms Checklist which included to dust/spot clean windows, sills, walls, furniture etc. and to dust mop and wash all resident floors.
Staff and residents identified that at the time of the inspection the home was in the process of a painting project.
Painting contractors were observed in a room and according to residents a second room was painted sometime the week prior.
Two days after the contractors were observed dry wall dust and other debris was observed on the floors and baseboards in the bedrooms and bathrooms of the two rooms, as confirmed by staff.

Failure to clean resident bedrooms and bathrooms daily as set out in the procedure resulted in unclean rooms.

Sources: Observations of resident rooms, review of the Cleaning Procedure: Bedrooms - Daily procedure and interviews with residents and staff. [168]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Rational and Summary
A resident's clinical record included a continence assessment which identified they were continent, and no interventions were required. No additional continence specific assessments were included in the clinical record.
A review of recent assessments identified the resident had a deterioration in their level of continence. Failure to complete a continence assessment when the resident was incontinent had the potential for incomplete assessments of continence status and the development and implementation of an individualized plan of care.

Sources: Plan of care and assessments of a resident and interview staff. [168]

WRITTEN NOTIFICATION: General Requirements

NC #08 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure any actions taken with respect to a resident under the Nursing and Support Services program including assessments, interventions and the resident's responses to interventions were documented.

Rational and Summary
i. A resident slept in an alternate location for five days due to a concern.
A review of the clinical record did not include any assessments or documentation during the night shifts related to where or how the resident slept, nor the resident's response to sleeping in the alternate

location.
ii. A resident was involved in an incident with a co-resident.
Progress notes by staff identified they would check in on the resident during the following shift.
A review of the progress notes did not include any documentation for the shift.
Staff confirmed they did follow up during the shift; however, failed to document their intervention or the resident's response.
Failure to document assessments, interventions or the resident's response had the potential for successful interventions or strategies for concerns not to be identified and or implemented.

Sources: Review of the progress notes, electronic Medication Administration Records (eMAR) and Point of Care (POC) records for a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: Privacy curtains

NC #09 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 16

The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

Rational and Summary
i. Observations of a shared room noted that the privacy screens did not easily retract between the beds, nor did they provide complete privacy around the second bed in the room.
ii. Four shared resident bedrooms were observed to be missing the small privacy curtains at the head of the beds under the bulkheads.
The missing curtains were brought to the attention of staff, and it was reported they had been temporarily removed due to painting and were rehung at that time.

Sources: Observations of resident rooms and interviews with staff. [168]

WRITTEN NOTIFICATION: Dealing with complaints

NC #10 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included, related to complaints, every date on which any response was provided to the complainant, a description of the response.

Rational and Summary
A complaint was received by the home related to care provided to a resident.
A review of the Concern/Complaint Form, Critical Incident Report, and progress notes did not include when or if a response was provided to the complainant as confirmed by staff.

Sources: Review of Concern/Complaint Form, Critical Incident Report, Complaints Log and progress notes for a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Dealing with complaints

NC #11 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (2) (f)

The licensee has failed to ensure that a documented record, related to complaints, was kept in the home that included the response from the complainant.

Rational and Summary
A complaint was received by the home related to the care provided to a resident.
A review of the Concern/Complaint Form, Critical Incident Report, and progress notes did not include the response from the complainant as confirmed by staff.

Sources: Review of the Concern/Complaint Form, Critical Incident Report, Complaints Log and progress notes of a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #12 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with.

Rational and Summary
The home's policy, titled LTC Abuse - Zero Tolerance Policy Abuse and Neglect, identified that suspected and or confirmed allegations of abuse were to be reported immediately. Persons who had reasonable grounds to suspect abuse were to immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse who were responsible to report to the Ministry (Director) immediately. The policy also included, but was not limited to, directing the most Senior Administrative Personnel or Charge Nurse to commence a preliminary investigation which would be followed up by the Administrator or Director of Care.

Staff #117 was present during an interaction between two residents which caused one of the residents to have a response.
Staff #117 informed staff #118 of the incident and asked them to report the interaction.
Staff #118 notified their supervisor of the interaction; however, specific details were not provided.
The supervisor reported they were unaware of the specific details, the response of the resident, nor had they asked for additional information to determine if the incident was or had the potential to be abuse. They did not report the interaction to the most Senior Administrative Personnel or Charge Nurse, nor initiate an investigation as directed in the home's abuse policy.
The incident was not reported to the Director nor investigated until it was discussed by the Inspector, during the inspection.
Failure to comply with the home's policy prevented the Director from conducting an inquiry or inspection to ensure compliance with the requirements under the Act and delayed the implementation of measures to support a resident and assist a second resident.

Sources: Review of a Critical Incident System (CIS) report, review of LTC Abuse – Zero Tolerance Policy for Resident Abuse and Neglect, review of clinical health records of residents, and interviews with staff. [168]

WRITTEN NOTIFICATION: Residents' drug regimes

NC #13 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 134 (a)

The licensee has failed to ensure that when a resident took a drug or combination of drugs they were

monitored and there was documentation of their response and the effectiveness of the drugs, appropriate to the risk level of the drugs.

Rational and Summary
On April 11, 2022, the FLTCA and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA.
As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 134 (a) of O. Reg. 79/10.

In January 2022, a resident voiced a concern, and the physician increased their dose of a medication, in an effort to manage the symptom.
In March 2022, the resident again reported the concern, and the physician prescribed a second medication to be administered.
Subsequently orders were received to wean the resident off the second medication and to use the first medication only as needed due to concerns expressed by the resident's family.
The progress notes, eMAR for January and March 2022, nor POC records from January until April 2022, included that the resident was monitored or their response to the drugs documented.
Failure to monitor and document the effectiveness or the resident's response to the drugs had the potential for the resident to experience undesired effect(s) of the medications.

Sources: Review of the clinical health record of a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: Plan of care

NC #14 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the care set out in the plan of care was provided to a resident as specified in the plan.

Rational and Summary
A resident sustained a fall during an evening shift.
The post fall assessment directed the day nurse to call the power of attorney (POA)
A progress note written by staff related to the fall also indicated the day nurse was to notify the POA.
There was no documentation in the clinical record the following day that the resident's family was

notified of the fall or why they were not informed of the incident.
Interview with staff who worked the day shift following the fall was unable to recall the shift; however, noted if they called the family, they would document their action.
Interview with a manager noted they would not have expected staff to notify the family of the fall unless it was a request of the resident due to information included in the clinical record.
The resident reported they assumed their family would have been notified of the fall.
There was a delay in family notification of the fall as a result of staff not following the plan of care.

Sources: Review of progress notes, assessments and contact information for a resident and interviews with the resident and staff. [168]

WRITTEN NOTIFICATION: Plan of care

NC #15 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure there was a written plan of care for a resident that set out the planned care for the resident.

Rational and Summary
A resident was assessed by the RD.
The assessment included a plan to offer a specific beverage at lunch and dinner.
A review of the current Master Diet List did not include to offer the beverage at dinner.
The planned care was included in the progress notes/RD response to the referral; however, was not on the Master Diet List, which dietary aids accessed at the point of meal service.
Failure to include the planned care for the resident on the Master Diet List/plan of care increased the risk that the resident would not be provided the intervention as suggested by the RD.

Sources: Review of Master Diet List/plan of care and RD assessment for a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Plan of care

NC #16 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when their care needs changed.

Rational and Summary
The plan of care for a resident included a focus statement for sleep and rest.
The plan addressed issues related to their preferred bedtime and a care need.
The eMAR provided direction for staff to provide specific care during the night shift.
Due to a concern the resident slept in an alternate location for five days until a solution was identified.
The plan of care was not reviewed or revised when their care needs changed, and the resident slept in the alternate location.
Failure to review or revise the plan of care with changes in the resident's care needs had the potential for the care needs to not be met.

Sources: Review of the eMAR, assessments, POC records, progress notes and plan of care for a resident, review of Concern/Complaint Form, review of Maintenance Repair Request forms and interviews with staff. [168]

WRITTEN NOTIFICATION: Plan of care

NC #17 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for two residents set out clear directions to staff and others who provided direct care to the residents.

Rational and summary
i. A resident's plan of care related to toileting noted they were to be checked at regular intervals and provided direction related to product usage.

The eMAR identified staff were to provide specific care at night and to document if the care was refused.
Staff reported care was routinely provided around a specific time during the night shift.
A second staff member reported the resident informed staff when continence care was needed; however, routinely care was provided around a specific time during the day shift.
The clinical record and complaints log included occasions where the resident reported concerns related to their continence care needs not being met.
Failure to ensure the plan of care provided clear direction related to the timing of regular interval checks had the potential for the resident not be afforded care consistent with their needs.

ii. A second resident was assessed and used a product for containment.
The plan of care related to toileting noted the resident was to be checked at regular intervals, directions related to product usage and that they would ask to void. The plan under bladder continence identified direction related to the resident directing their own care. Staff interviewed indicated conflicting information related to the level of assistance and timing of interval checks.
A document identified that on a specific date the resident was not immediately provided continence care at a specific time due to the availability of staff.
Failure to ensure the plan of care provided clear direction related to the level of assistance with continence care and the timing of regular interval checks had the potential for the resident not be afforded care consistent with their needs.

Sources: Interviews with residents, observations of the residents, a review of the continence assessments and plans of care and interviews with staff. [168]