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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 26, 2023	
Inspection Number: 2023-1196-0003	
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: Bloomington Cove Care Community, Stouffville	
Lead Inspector Elaina Tso (741750)	**Inspector Digital Signature** Elaina Tso Digitally signed by Elaina Tso Date: 2023.10.16 13:15:38 -04'00'
Additional Inspector(s) Amandeep Bhela (746) Eric Tang (529)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15 to 16, 18, 23 to 25, 29 to 31, and September 1, 2023.
The inspection occurred offsite on the following date(s): August 17, 21 to 22, and 28, 2023.

The following intake(s) were inspected:

- One intake of a complaint related to an unknown cause of fractures of a resident.
- An intake related to an unknown cause of injury of a resident.
- Intake: #00085094 - First follow up to High Priority Compliance Order (CO) #001/#2023_1196_0002, FLTCA, 2021 - s. 24 (1), Compliance Due Date (CDD) May 31, 2023.
- Intake: #00085095 - First follow up to High Priority Compliance Order (CO) #002/#2023_1196_0002, FLTCA, 2021 - s. 25 (1), CDD May 31, 2023.
- Intake: #00085096 - First follow up to High Priority Compliance Order (CO) #004/#2023_1196_0002, O. Reg. 246/22 - s. 272, CDD May 31, 2023.
- Intake: #00085097 - First follow up to High Priority Compliance Order (CO) #003/#2023_1196_0002, FLTCA, 2021 - s. 28 (1) 2, CDD May 31, 2023.
- Intake: #00085098 - First follow up to High Priority Compliance Order (CO) #005/#2023_1196_0002, O. Reg. 246/22 - s. 102 (2) (b), CDD July 16, 2023.
- Two intakes related to staff to resident verbal abuse.

- Three intakes related to resident to resident responsive behaviours.
- One intake of a complaint related to neglect, resident's diet, restorative, recreational and care concerns.
- An intake related to staff to resident verbal and physical abuse.
- An intake related to respiratory outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1196-0002 related to FLTCA, 2021, s. 24 (1) inspected by Amandeep Bhela (746)

Order #002 from Inspection #2023-1196-0002 related to FLTCA, 2021, s. 25 (1) inspected by Amandeep Bhela (746)

Order #004 from Inspection #2023-1196-0002 related to O. Reg. 246/22, s. 272 inspected by Elaina Tso (741750)

Order #003 from Inspection #2023-1196-0002 related to FLTCA, 2021, s. 28 (1) 2. inspected by Amandeep Bhela (746)

Order #005 from Inspection #2023-1196-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Elaina Tso (741750)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure a resident was treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) alleging a Personal Support Worker (PSW) interacted inappropriately towards a resident during morning care.

The resident was admitted to the Long-Term Care Home (LTCH) with various health conditions. Resident's electronic care plan documented that their psychological health condition might fluctuated. When it happened, staff were to gently remind them, and to re-approach them when settled.

During morning care episode, the resident suddenly became upset and had an interaction with the PSW. When interviewed, the PSW confirmed that they had interacted inappropriately towards the resident. As a result, they were suspended for a day and could no longer provide care to the resident. The PSW was remorseful of their behaviour and was also able to verbalize techniques to be utilized to the resident as per their electronic care plan when the resident exhibited the psychological health condition. The Associate Director of Care (ADOC) stated that the nursing staff were to honor the Residents' Bill of Rights and confirmed the PSW did not treat the resident with dignity, respect, and courtesy during the identified care episode.

There was risk and impact to the resident as the inappropriate interaction from the PSW might have temporary affected their emotional state.

Sources: resident's electronic health records, home's internal investigations, and interviews with PSWs and ADOC. [529]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was submitted to the MLTC related to a resident who had contacted a disease, but the SDM was not made aware by the LTCH. The SDM was informed by the external care facility when the resident was admitted there later on.

The home's records confirmed through test results the resident was diagnosed with the disease but there were no records of the home informing the SDM.

The RPN confirmed the same and that they did not call the SDM, as the home's management team would be required to inform the SDM.

The ADOC confirmed that RPN should have informed the resident's SDM of the test result.

By the home failing to inform the SDM, the resident was at potential risk as the SDM was not able to fully participate in resident's plan of care.

Sources: resident's electronic records and interviews with RPN and ADOC. [746]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident received a skin assessment by a member of the registered staff, using a clinically appropriate instrument that was designed for skin and wound assessment.

Rationale and Summary

A complaint was submitted to the MLTC related to a resident's transfer due to a skin issue on their lower extremity. Further assessment identified the resident had some old fractures in other parts of the body.

The home's records, investigation notes and interview with the PSW confirmed that the RPN was informed of the skin issue on their lower extremity. The RPN had only visually assessed the area and instructed the PSW to inform them if it got worse.

The ADOC confirmed that the RPN failed to complete a skin assessment upon identification of the resident's skin issue on their lower extremity.

Failure to complete a skin assessment, put the resident at risk for delayed treatment and intervention.

Sources: resident's health records, home's investigation notes and interviews with PSW and ADOC. [746]

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) (iv)

The licensee has failed to ensure a resident was reassessed at least weekly by a member of the registered nursing staff when the resident exhibited altered skin integrity.

Rationale and Summary:

A CIR was submitted to the MLTC alleging a resident was abused by the PSW during care and resulted in an injury.

As per resident's electronic record, the PSW discovered a new wound on the resident's upper extremity when undressed during care. The wound was actively bleeding and the RPN was called to assist with wound care. A review of the home's skin and wound care management protocol indicated that a skin and wound assessment was to be completed when a resident exhibited altered skin integrity, including skin tears, and the assessment was to be completed weekly until the skin alteration was resolved. Upon reviewing the resident's electronic chart, the initial skin and wound assessment was completed by the RPN, but the following two weeks assessments were not completed. The wound was healed after the third week.

When interviewed, both the RPN and the Director of Care (DOC) confirmed that a skin and wound assessment was to be completed when a resident exhibited altered skin integrity. However, it was not completed for two weeks.

There was a moderate risk and impact to the resident as the lack of skin and wound assessments could have hindered the wound healing process.

Sources: resident's electronic health records, and interviews with RPN and the DOC. [529]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to ensure the implementation of interventions to mitigate and manage nutritional risks for a resident.

Rationale and Summary

A complaint was submitted to the MLTC alleging the home had not followed a resident's diet as per their plan of care.

The resident's electronic health records documented that they had chewing, swallowing issues and at risk of choking. The resident required a special diet texture in order to minimize their risks. An observation was made in which the resident was provided and consumed a food item that was inappropriate for their diet texture.

The Registered Dietitian (RD) stated that the resident was required to be on a special diet texture and the resident was not to be provided the observed food item as it increased their risk for choking. The RD further asserted that the food item should have been modified before being given to the resident.

There was a moderate risk to the resident as they were not served food of correct texture which increased their risk for choking.

Sources: observation, resident's health records, and interview with the RD. [741750]

COMPLIANCE ORDER CO #001 Retention of records

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 276 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 276 (1).

Specifically, the licensee shall:

1. Retrain the management team on the Privacy Policy, 11-C-10.00, Personal Information Protection, 11-B-10.30, and legislative requirements around retention of records, including staff who are responsible for preparing, handling and storing charts for resident's who are discharged. Designate a corporate/lead to deliver the education. Document the date of the education provided, the name of the person who provided the education and the names of the staff who completed the education. Make this information available upon request.

2. Inform resident's SDM of missing physical chart, make this information available to inspectors upon request.

Grounds

Non-compliance with: O. Reg. 246/22, s. 276 (1)

The licensee failed to ensure that a resident's physical chart was retained by the licensee for at least 10 years after the resident is discharged from the home.

Summary and Rationale

A complaint was submitted to the MLTC related to a resident was transferred to an external care facility due to lower extremity problem. The resident was then identified with some old fractures in their body.

The Executive Director (ED) confirmed that the resident's physical chart was missing upon request by the Inspector. The ED further indicated that the home attempted to continue their efforts in locating the physical chart for the resident.

The resident's missing chart putting them at risk for personal health information and personal information breach.

Sources: interview with the ED and email confirmation. [746]

This order must be complied with by October 30, 2023

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.