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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Original Public Report

Report Issue Date: November 2, 2023	
Inspection Number: 2023-1196-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Bloomington Cove Community, Stouffville	
Lead Inspector Jennifer Brown (647)	**Inspector Digital Signature**
Additional Inspector(s) Sheri Williams (741748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 19, 20, 23, 24, 2023.

The following intake(s) were inspected:

- Intake related to a Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect

Quality Improvement
Pain Management
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)
FLTCA, 2021, s. 85 (3) (d)

The licensee has failed to ensure that the required information for the purposes of subsections (1) and (2) was posted; specifically, an explanation of the duty under section 28 to make mandatory reports.

Summary and Rationale
During the initial tour of the home, it was identified that the mandatory posting of the explanation to the duty under section 28 to make mandatory reports was last revised in June 6, 2019, and therefore did not have the current legislative requirements. The Executive Director confirmed that the explanation to the duty under section 28 to make mandatory reports was outdated.

Current policy information related to the duty under section 28 to make mandatory reports would allow the home to report to the Ministry of Long Term Care as per the current regulations.

Sources: Duty to Report policy, XXIII-D-10.20, last revised June 6, 2019, and an interview with the Executive Director. [647]

Date Remedy Implemented: October 19, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 the plan of care was reassessed and reviewed for a resident when the care set out in their plan was no longer necessary.

Rationale and Summary

The plan of care for the resident included the use of two specific interventions.

During an observation of the resident, they were observed to have neither interventions in place.

A Personal Support Worker (PSW) indicated that the specific interventions for the resident were no longer required.

The Director of Care (DOC) acknowledged that they were aware that the resident no longer required the specific interventions and their plan of care should have been updated.

Failing to update the plan of care, when care was no longer necessary, posed a low risk to the resident as they would not have their care needs met.

Sources: Resident's clinical records, observations and interviews with the resident, PSW and DOC .

[741748]

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee failed to keep a written record relating to each program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary

The home's annual evaluations for the required programs of Pain Management, Skin and Wound Management and Falls Prevention, did not document any names of participants or the dates they were reviewed.

The Associate Director of Care (ADOC) and DOC confirmed they were aware the program evaluations were to be interdisciplinary and that they were not completed.

Failure to complete a program evaluation and keep a written record posed a risk that changes for improvement were not implemented nor evaluated.

Sources: Program evaluations for pain management, skin and wound management, falls prevention; interviews with ADOC and DOC.

[741748]

WRITTEN NOTIFICATION: Nutrition Manager

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (1)

The licensee has failed to ensure that there was a nutrition manager for the home to lead the nutritional care and dietary services program for the home.

Rationale and Summary

During the PCI, an Internal Telephone Directory was provided that listed the Program Manager as the Interim Nutrition Manager for the home.

The Executive Director (ED) acknowledged that the Nutrition Manager position was vacant since the beginning of September 2023.

Failing to ensure the home had a nutrition manager posed potential harm in the delivery of dietary services were provided to residents in accordance with their preferences and needs.

SOURCES: Internal telephone directory, Interviews with staff, DOC and ED.

[741748]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team met quarterly to evaluate, which must include the Medical Director, the Executive Director, the Director of Nursing and Personal Care, and the pharmacy service provider to evaluate the effectiveness of the medication management system in the home.

Rationale and Summary

During the PCI, the home was asked to provide a copy of their quarterly medication evaluation and was not able to provide one.

The ADOC advised that they were aware that the medication management program of the home was to be evaluated quarterly with an interdisciplinary team.

The DOC and ED acknowledged that a quarterly evaluation was not completed.

Failing to ensure that the quarterly evaluation was interdisciplinary, posed a risk to the home that the medication management system was not evaluated for the effectiveness of the program.

Sources: Annual Program Evaluation, interviews with ADOC, DOC and ED

[741748]

WRITTEN NOTIFICATION: Annual Evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Executive Director, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:

The Professional Advisory Committee (PAC) meeting minutes indicated the last meeting was held in September 2022.

The ADOC, DOC and Executive Director acknowledged that they were aware that an annual evaluation of the medication management program was required to be interdisciplinary and confirmed that it was not completed.

By failing to have an annual interdisciplinary review of the home's medication management system posed a risk of changes and improvements not being implemented as required.

Sources: Review of the home’s PAC meeting minutes, and interviews with the ADOC, DOC and Executive Director.

[741748]