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: 2023-1389-0004	
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: Bradford Valley Community, Bradford	
Lead Inspector Ana Best (741722)	**Inspector Digital Signature** Ana G. Best Digitally signed by Ana G. Best Date: 2023.11.09 12:53:33 -05'00'
Additional Inspector(s) Nicole Lemieux (721709)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12-13, 16 to 20, 2023.

The following intake(s) were inspected:

- Intake: #00098675 - 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
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee failed to ensure that the nutritional care and hydration program implemented interventions for a resident to mitigate and manage risks specific to their dietary restrictions.

Rationale and Summary

While conducting a Proactive Compliance Inspection (PCI), a resident was served a specific soup for lunch. The resident's clinical records and the home's meal service report indicated that the resident had a food intolerance related to a medical diagnosis. Both the resident and a Personal Support Worker (PSW) confirmed they were served soup which included the resident's specific food intolerance. Further discussion and review with the PSW confirmed that the resident did receive the specific soup for lunch and the interventions outlined for the resident's nutritional restrictions were not implemented.

Failing to provide the resident with the appropriate foods puts the resident at increased health risk.

Sources: Observations, posted menu, meal service report, the resident's clinical records and interview with a PSW. [721709]

WRITTEN NOTIFICATION: Menu planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary

The planned menu for a specific date, indicated that the lunch meal was to comprise of Italian wedding soup as the first course. Observations of the lunch service confirmed that the residents received tomato soup instead of the Italian wedding soup. The Dietary Aide's (DA's) temperature logs for the day also

indicated that Italian wedding soup was to be served, however documentation showed tomato soup was hand-written on the sheet.

Direct care staffs and the DA confirmed that tomato soup was served to the residents for lunch. Furthermore, both the DA and Dietary Manager confirmed that the planned menu was not followed.

Failing to provide the planned menu may impact the residents' enjoyment of their meal and can negatively impact the quality of meal service.

Sources: Observations, posted lunch menu, weekly posted menu, temperature logs, and interviews with staff and management. [721709]

WRITTEN NOTIFICATION: Food production

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

The licensee has failed to communicate menu substitutions to residents and staff.

Rationale and Summary

There was a change in the planned menu for a specific date. The planned and posted menu for the residents indicated that Italian wedding soup was to be served, however tomato soup was served. Prior to and throughout the meal, the change in menu was not communicated to the staff or residents verbally. Additionally, there was no written change in menu postings on the planned and posted menu communication board.

Two direct care staff indicated that the home's process was to post the change in menu on the posted menu board to alert all residents and staff as well as receive verbal communication from the DA regarding any changes in menu. Both direct care staff confirmed that this process was not followed prior to the lunch service. Furthermore, the Dietary Manager confirmed that the change in menu was not posted or communicated prior to the residents or staff.

Failure to communicate menu substitutions to residents and staff negatively impacts the quality of meal service.

Sources: Observations, and interviews with staff and management. [721709]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee failed to ensure that procedures were implemented for the cleaning and disinfection of resident care equipment.

Rationale and Summary

During a tour on a specific unit, a PSW was observed entering a room with a transfer device and care items in their hand to assist a resident with their care needs. Staff were observed exiting the room shortly after with the resident, leaving the transfer device inside the room without completing the cleaning and disinfection of the equipment. The PSW portered the resident to the dining room and then proceeded to enter the servery area getting ready to assist in the dining room.

The Long-Term Care Home's (LTCH) equipment cleaning policy specified all shared equipment must be cleaned and disinfected between resident uses. For the transfer device, it specifically stated to apply the disinfectant product, paying special attention to high touched surface areas and to leave the product on the device for ten minutes.

The PSW confirmed they entered the room with a transfer device to assist a resident with their care needs, and they exited the room without completing the cleaning of the device. The PSW acknowledged the used equipment was to be cleaned with disinfectant wipes after each use.

Failure to clean and disinfect residents' care equipment including transfer device, could contribute to the spread of infectious agents in the home.

Sources: Observations, LTCH's Equipment Cleaning – Resident Care and Medical policy, and interview with a PSW. [741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that a resident's symptoms indicating the presence of infection were monitored on every shift.

Rationale and Summary

During a tour of a specific unit, a signage was posted on a resident's room door indicating additional precautions were in place.

The resident's progress notes indicated the resident was tested for an infection. A couple of days later, it was documented the test result was positive for the infection. There was no documentation related to

the monitoring of the resident on multiple shifts over a three-day period following the confirmation of the infection.

The Associate Director of Care (ADOC) confirmed the registered staff failed to monitor the resident on the identified shifts, and they had addressed this with the staff. Furthermore, the ADOC indicated the expectations were to monitor the resident with daily using specific assessments and documenting in the resident's clinical records.

Failure to monitor the resident's infectious symptoms every shift increased the risk of an unidentified worsening condition for the resident.

Sources: Observations, resident's clinical records and interview with the ADOC. [741722].