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
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Original Public Report

Report Issue Date: July 12, 2024
Inspection Number: 2024-1389-0002
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: Bradford Valley Community, Bradford

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24 - 28, 2024 and July 3 - 5, 2024
The inspection occurred offsite on the following date(s): July 2, 2024

The following intake(s) were inspected:
- Two intakes related to outbreaks.
- Two intakes related to falls.
- One complaint intake related to improper transfer.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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 with an intervention, as specified in the plan of care.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to a resident's fall resulting in a significant change in the resident's health status.

The resident was observed in their room without their specified intervention. After several minutes, Registered Practical Nurse (RPN) #106 was observed applying the resident's intervention

The resident had instructions in their plan of care to reduce their risk of injury related to falls.
RPN #106 confirmed that the resident was in their room without their specified falls intervention and acknowledged that there were directions for the intervention to be followed for the resident's safety.

Failure to ensure that the resident had their intervention in place put the resident at

a higher risk of injury in the event of a fall.

Sources: Observations, health records for resident #002, interview with RPN #106.

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that doors leading to balconies and terraces, were kept closed and locked.

Rationale and Summary
During the inspection, it was observed that the door located in the dining room leading to the balcony area on a specific home unit was left open, with a brick at the bottom of the door preventing its closure. Residents were observed seating and walking in the surroundings, and no staff was observed supervising the door. During the observation period, two residents were observed exiting to the balcony, one of them was redirected by RPN #115.

Personal Support Worker (PSW) #116 and RPN #115 confirmed the door was left open, and the recreation aid was the assigned staff to supervise the residents and

the door if residents were in the balcony.

Recreation staff #117 indicated they were not supervising the door as they were in the kitchen preparing for an activity for the following day, and confirmed the door should have been closed and locked, or supervised if residents were outside in the balcony area.

The Director of Care (DOC) indicated doors leading to the balcony area should be kept closed and locked, if residents went outside to the balcony, supervision from the recreation staff was required.

Failure to ensure the door to the balcony area was not closed and locked, placed the residents on the home unit at risk of harm and injury.

Sources: Observations, interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee has failed to ensure that an interdisciplinary assessment related to a resident's safety risk for a specific intervention was completed.

Rationale and Summary

A resident was observed in their room, with a specific intervention in place.

Review of the resident's health records identified that they required assistance with Activities of Daily Living (ADLs). There were no instructions related to the use of this intervention for this resident.

RPN #115 verified that an intervention was to be implemented for the resident for positioning purposes and acknowledged that this was not documented in the resident's plan of care.

Associate Director of Care (ADOC) #119 acknowledged that there was no indication for the use of this intervention for the resident within the plan of care and reported that no assessment in relation to the safety risk of using this intervention for this resident was completed. Further, ADOC #119 acknowledged the potential safety risk to the resident related to the implementation of the intervention.

Failure to ensure the completion of an interdisciplinary assessment in relation to the safety risks of utilizing a specific intervention for the resident , increased the risk of harm to the resident.

Sources: Observation, health records for resident #002, interviews with RPN #115 and ADOC #119.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the

review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the Falls Prevention and Management Program provided strategies to reduce or mitigate falls, including the monitoring of a resident

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the Falls Prevention and Management Program, at minimum, provides strategies to reduce or mitigate falls, including the monitoring of residents and that those strategies are complied with.

Specifically, the registered staff did not comply with the monitoring of a resident after they sustained an unwitnessed a fall, as required by the "Falls Prevention and Management" policy, under the home's Falls Prevention and Management program.

Rationale and Summary
A CIR was submitted to the Director related to a resident's fall resulting in a significant change in health status.

The resident sustained an unwitnessed fall. The home's Falls policy revealed that as part of a post falls assessment, the nurse was to contact the physician and/or arrange for immediate transfer of resident to hospital and the Substitute Decision Maker (SDM) was to be notified. In addition, the nurse was to initiate a head injury routine for an unwitnessed fall and monitor the resident as per the schedule on the head injury routine form.

RPN #106 confirmed that after the resident's fall, the SDM was not notified on the

same day. In addition, the nurse indicated that the physician was not contacted.

ADOC #119 acknowledged that the head injury routine for the resident was not completed as per the scheduled intervals or as per the home's policy.

By failing to ensure completion of the head injury routine and that the resident's SDM and physician were informed after the unwitnessed fall, as per the home's Falls policy, interventions may have been overlooked and the resident was placed at a higher risk for decline in health status.

Sources: Resident #002's progress notes, Fall Prevention and Management policy, interviews with RPN #106 and ADOC #119.

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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that Point-of-care signage indicating than enhanced IPAC control measures was in place as it is required by Additional Precautions 9.1 (e) under the Infection Prevention and Control (IPAC) Standard for

Long Term Care Homes, dated September 2023.

Rationale and Summary
During a tour of the Long Term Care Home (LTCH), a caddie containing some Personal Protective Equipment (PPE) was observed outside two identified rooms on a specific home unit.

The LTCH's list of residents on precautions, identified one of the rooms to be on additional precautions due to an infection.

On different days, the inspectors observed that no signage was posted advising of enhanced IPAC control measures for the identified resident's room.

PSW #104 confirmed the resident on the specific room was identified to be on additional precautions and the caddie placed outside the rooms was related to that resident. In addition, PSW indicated a sign should have been posted on the resident's door to identify the room and the directions to be followed by staff.

The IPAC Lead confirmed the Point-of-care signage should be posted on the resident's door, indicating the point of care risk assessment and the required additional precautions.

Failure to ensure Point-of-care signage indicating than enhanced IPAC control measures were in place for the resident, posed a risk to further transmit infectious diseases in the home.

Sources: Observations, home's residents on precautions list, , interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

The licensee failed to ensure that when the SDM of resident #001 expressed their matter of concern related to the resident's skin condition, a documented record was kept in the home.

Rationale and Summary

A complaint was lodged to the Director related to resident #001's care concerns.

Resident #001's health records indicated that on a specific date, a skin condition was reported by the staff and the SDM was notified. The physician's note at the time, indicated the resident had a skin injury and that the resident's SDM was unsatisfied, , and management was involved.

ADOC #111 indicated they were notified by the nurse on the specific shift, and they had immediately assessed the resident. The ADOC completed an investigation, and

after meeting with the staff, the cause of the skin condition was identified as unknown. In addition, the ADOC confirmed the SDM was upset as information related to the location of the skin condition was different from what was reported to them.

The Associate Executive Director (AED) indicated the resident's SDM had requested a meeting with the AED, the Director of Care (DOC) and the Executive Director upon notification of the incident, but due to availability, ADOC #111 was requested to follow up with the SDM. Few days after, the SDM presented to the EDs' office with pictures of resident's #001 skin condition. The AED confirmed no written record related to this complaint was kept in the complaint binder.

Failing to ensure that records of the complaint related to resident #001 were documented and kept in the home, may have impacted how issues were addressed.

Sources: Resident #001's progress notes and assessments, LTCH's Complaints Binder 2024, ADOC's investigation notes, interviews with staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict

unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate all staff working on the identified home unit, of the importance of ensuring doors to non-residential areas are kept closed and locked when staff are not in attendance. Keep a documented record that includes:
a) Content of the education provided.
b) The date of the education, name and designation of staff educated, and who provided the education.
A record of the education is to be kept and made available to the Inspector upon request.

2. Conduct audits twice daily, once during the day shift and once during the evening shift to ensure all doors to non-residential areas in the identified home unit are kept closed and locked when not attended by staff.
a) The audits are to be conducted for a period of four weeks.
b) The audits are to be conducted by management.
c) The audits are to include: date, name and designation of auditor, location of the audited area, and any corrective action taken if a deficiency is identified.
Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

During a tour of the Long-Term Care Home (LTCH) on an identified home unit, it was observed the door to the utility room was open. Posted on the door, there was a sign indicating "eye washing station", and to keep the door closed. Inside the room it was observed sharp objects, chemicals, and supplies related to personal care.

During several minutes, the door was kept open with no staff observed in the surroundings. A resident was observed walking outside the utility room.

RPN #105 indicated the door should be closed and locked at all times.

There was risk of safety to the residents on the identified home unit, when action was not taken immediately when the utility room door was kept open.

Sources: Observations, interview with RPN #105.

This order must be complied with by September 16, 2024

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

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.