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

Public Report

Report Issue Date: March 3, 2025
Inspection Number: 2025-1389-0002
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 25-27, 2025

The following intake(s) were inspected:
- An intake related to the alleged neglect of resident. .

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from neglected by staff.

According to legislation, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date, a resident was observed to be experiencing a medical emergency.

RPN #106 completed an assessment of the resident and provided a specific directive to a specified individual in relation to the resident's condition and care. The resident's change in condition was reported to RPN #107 when they attended for their shift. Both RPN #106 and #107 failed to notify specified professionals with regards to the resident's change in status.

A review of clinical records as well as an interview with the LTCH's Director of Care (DOC) demonstrated that there was a lack of appropriate clinical response by staff during the emergency. The DOC also confirmed this care to be absent.

Following a medical assessment, the resident was assessed to have experienced a significant change in health status.

Sources: interview with identified individuals, review of clinical records.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure that a resident was served a meal on a course by course basis.

On a specified date, a resident was observed to be seated with two courses of their meal placed in front of them. PSW #101 confirmed that the resident had been served two courses simultaneously.

Sources: observation of resident and interview with PSW #101.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required mealtime assistance with not served a meal until someone was available to provide the assistance required.

On a specified date, a resident was observed to be seated in the resident dining area with a meal in front of them and no staff at the table to provide assistance.

According to the resident's care plan, they require full assistance.

Sources: observation, clinical records.

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