Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
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Public Report

Report Issue Date: June 3, 2025
Inspection Number: 2025-1389-0004
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): May 28 - 30, 2025 and June 3, 2025

The following intake(s) were inspected:

- An intake related to a fall with injury.

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

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

Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Resident #001's Medication Administration Records (MAR) recorded on a specific date an order for supplemental therapy. During inspection the resident was receiving the specified therapy. No sign was posted in the room indicating that a specific therapy was being administered, as confirmed by Associate Director of Care (ADOC) #104. The home's procedural sheet, indicated signs must be posted outside of the resident's room and on the front of the therapy delivery system to warn of potential hazards associated with it.

Sources: Observation, the home's procedural sheet, and interview with ADOC #104.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that resident #001's fall prevention interventions in their plan of care set out clear directions to staff and others who provided direct care to the resident.

During a specific month, resident #001 sustained several falls. After the latest fall reported, the resident required a transfer to hospital resulting in further medical treatment.
The resident's care directed the use of a specific intervention. Personal Support Worker (PSW) #102 and Registered Practical Nurse (RPN) #103 indicated different interpretations of the directions noted in the resident's care plan. ADOC #104 acknowledged that clear direction should have been provided to staff regarding when to use the specific intervention for resident #001, and this was not reflected in the resident's care plan.

Sources: Critical Incident Report (CIR), resident #001's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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 failed to comply with the home's Falls Prevention and Management Program policy when strategies to reduce or mitigate falls, including the implementation of falls prevention, were not implemented in accordance with resident #001's plan of care.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Falls Prevention and Management Program were

complied with. Specifically, the home's Fall Prevention and Management policy indicated that nursing staff were to monitor preventative interventions, and the PSWs to use fall prevention interventions identified on the resident's plan of care.

Progress notes from a specific date, indicated that resident #001 was not using an identified fall intervention at the time of a fall. ADOC #104 confirmed the fall intervention was not applied as directed in their care plan. Additionally, during inspection, it was identified and confirmed by PSW #102 and RPN #103 that falls interventions indicated in the resident's care plan were not implemented as directed.

Sources: CIR, observation, resident #001's health records, the home's Falls Prevention and Management, and interviews with staff.

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 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee failed to ensure the equipment and devices identified in the care plan for resident #001 related to the falls prevention and management were in place and in working condition.

Resident #001's clinical records indicated that as part of the fall interventions, a device was to be applied. PSW #102 indicated the required device was not applied as it was not in working condition, and it had been reported since the previous day.

Sources: Observation, resident #001’s health records, and interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee failed to comply with the home's pain identification and management program when resident #001 was identified to have pain.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for pain program were complied with. Specifically, the home's Pain and Symptom Management policy indicated that the nursing staff was to screen the presence of pain and complete a pain assessment when the resident reported or exhibited signs and symptoms of pain.

Resident 001’s health records indicated that no pain assessment was completed when the resident sustained a fall on specific date, and reported feeling soreness. Additionally, no pain assessment was completed on another date when pain was identified.

Sources: Resident #001's clinical records, the home’s Pain, and Symptom Management policy, and interview with staff.

WRITTEN NOTIFICATION: Pain management

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

Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to comply with the home's pain management program when resident #001 was identified to have pain and strategies to manage pain, including non-pharmacological interventions, were not implemented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain program were complied with. Specifically, the home's Pain and Symptom Management policy indicated the implementation of pharmacological and/or non-pharmacological interventions when the resident reported or exhibited signs and symptoms of pain.

Resident #001's clinical records indicated the resident had identified pain on specific dates, in which both pharmacological and non-pharmacological interventions were not implemented. The pain lead confirmed that interventions should have been implemented and documented accordingly.

Sources: Resident #001's clinical records, the home's Pain and Symptom Management policy, and interview with staff.