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

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Original Public Report

Report Issue Date: March 28, 2024
Inspection Number: 2024-1412-0001
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: Woodhall Park Community, Brampton

Lead Inspector	**Inspector Digital Signature**
Gurvarinder Brar (000687)	Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2024.04.19 14:18:32 -04'00'

Additional Inspector(s)
Romela Villaspir (653)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11 - 15, & 19 - 22, 2024

The following intake(s) were inspected:

- Intake: #00110386 - Proactive inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
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)
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 licensee failed to ensure that a door leading to a non-residential area was kept closed and locked when not supervised by staff.

Rationale and Summary
The tub room door with a numeric pin-pad was left unlocked and propped open.

The Personal Support Worker (PSW) closed the door and indicated that this door was supposed to be locked.

Sources: Inspector #653's observation; Interview with PSW. [653]

Date Remedy Implemented: March 11, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 the standard issued by the Director with respect to IPAC, was implemented.

Rationale and Summary
According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

According to Licensee Equipment Cleaning – Resident Care & Medical policy, all shared equipment (i.e. tub chairs/shower chairs/commodes/lifts, etc.) must be cleaned and disinfected after each use by team members using the item (i.e. nursing). Housekeeping will also follow a scheduled cleaning and disinfection of these items as assigned.

During the inspection, two PSW's transferred a resident using a Hoyer Lift from their

bed to chair. Then one of the PSWs placed the Hoyer lift in Tub room without disinfecting it.

The IPAC Lead indicated that the home's expectation was for the PSWs to disinfect the shared equipment after each use.

The PSW confirmed that they disinfected the Hoyer Lift after completing the interview with the Inspector.

Failure to adhere to the home's IPAC policies and procedures, resulted in the risk of spreading infectious microorganisms.

[000687]

Date Remedy Implemented: March 14, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 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 failed to ensure that the care set out in resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident was on special diet because of a medical diagnosis they had.

During a lunch meal service, the resident was offered food items from the regular

menu, and not the special diet menu.

The Registered Dietitian (RD) acknowledged that resident's plan of care was not followed, and indicated that staff should have offered the options on the special diet menu, and not the regular menu.

When a resident's plan of care was not implemented, the resident consumed food items that were not in accordance with their special diet.

Sources: The home's regular menu cycle and special diet menu; lunch meal observation; Interviews with RD and other staff. [653]

WRITTEN NOTIFICATION: DUTY TO RESPOND

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to respond to the Residents' Council (RC) in writing, within 10 days of receiving the advice of the RC related to a concern about the operation of the home.

Rationale and Summary
The President of RC indicated that during the RC meeting they had brought forward a concern and the RC did not receive a response in writing from the home.

The Director of Resident Programs (DRP) acknowledged that a response in writing was not provided to the Residents' Council within ten days of receiving their

concerns.

Sources: Residents' Council meeting minutes; Interviews with the President of Residents' Council, DRP, and the Executive Director (ED). [653]

WRITTEN NOTIFICATION: MENU PLANNING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes 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 the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a written record was kept of the menu cycle evaluation.

Rationale and Summary
Registered Dietitian (RD) and Director of Dietary Services (DDS) evaluated the home's menu cycle prior to it being in effect.

The home's menu evaluation and approval record was signed off by RD however, there was no documentation if Director of Dietary Services (DDS) signed off.

Sources: Menu Evaluation & Approval Record; Interviews with RD and DDS. [653]

WRITTEN NOTIFICATION: MENU PLANNING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a planned menu item was offered and available at each meal.

Rationale and Summary
During a lunch meal observation, the planned menu item was not offered to the residents.

The Food Service Supervisor (FSS) indicated that the expectation was for the staff to offer the planned menu item.

By not offering the planned menu item, the residents were not provided an opportunity to make their own choice during the lunch meal service.

Sources: The home's menu cycle; lunch meal observations; Interviews with FSS and other staff. [653]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
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:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to ensure that the home had a dining service that included a

process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

Rationale and Summary
A Resident was at high nutritional risk. The resident's care plan indicated under approaches/ support actions to offer specific food items.

The special needs related to the residents diet were not included in the meal service report where FSW's look to identify the needs of the residents prior to serving them.

By not adding the resident's specialized diet interventions on the meal report system, the FSW was not aware that the resident was supposed to be offered individualized diet during meal service.

Sources: Resident clinical health records, meal service report; Interviews with RD, FSW and FSS. [653]

WRITTEN NOTIFICATION: Infection prevention and cntrol program

NC #008 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).

A) The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff.
The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes

revised September 2023 (IPAC Standard) section 10.2 (c) related to resident hand hygiene stated that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before snacks.

Rationale and Summary:
During an afternoon snack pass, residents were observed not being offered hand hygiene before serving snacks by two Personal Support Workers (PSWs).

The IPAC Lead stated that staff were expected to offer hand hygiene for the residents prior to serving snacks.

By not performing hand hygiene, there was an increased risk of microorganism transmission among the residents and staff.

Sources: Snack observation, Licensee Hand Hygiene Policy and interviews with PSW and IPAC lead. [000687]

B) The licensee failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary
According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), revised in September 2023, section 9.1, indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: f) Additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal. The home's Additional Precautions policy indicated that the nurse will initiate the appropriate Additional Precautions at the onset of symptoms and maintain

precautions until laboratory results are available to confirm or rule out the diagnosis. For suspected/ confirmed COVID-19, the PPE to be used are N95 respirator (fit tested, seal checked), gown, gloves, and eye protection.

A resident had an intermittent symptom. A Polymerase Chain Reaction (PCR) test was collected, and the resident was placed on additional precautions.

The additional precautions signage was posted on the resident's door including the steps for removing PPE.

An Registered Nurse (RN) and Registered Practical Nurse (RPN) were inside a resident's room without wearing required PPE. The RN and RPN were checking on the resident and on the medical intervention equipment used by the resident in the room.

Upon exiting the room, the RN did not followed steps of doffing PPE.

The IPAC Lead indicated that the RN and RPN should have donned required PPE when entering the resident's room as the resident was on additional precautions and had a pending PCR test result. The IPAC Lead also stated that the RN should have followed the steps of doffing PPE.

By not adhering to the home's IPAC policies and procedures related to additional precautions, there was an increased risk for spreading infectious microorganisms amongst the residents and staff members.

Sources: The home's Additional Precautions policy; resident clinical health records; observations; Interviews with the IPAC Lead, and the registered staff. [653]

WRITTEN NOTIFICATION: Medication management system

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies were implemented that were developed for medication management in accordance with evidence-based practices for a resident.

A) Rationale & Summary
According to Documentation of Narcotic and Controlled Medication Counts policy, when administering the Narcotic/Controlled medication, the nurse documents for the administration of the medication on the resident's MAR and on the Resident Narcotic/Controlled Medication Count Record. They would subtract and document the remaining supply on the Resident Count Card. Verify the quantity recorded to the actual quantity.

A Registered Practical Nurse (RPN) administered a narcotic medication to a resident. The RPN did not sign the individual resident narcotic/controlled medication count record sheet at the time of administration.

The ADOC stated nurses were expected to sign off the narcotic/controlled medication count record sheet for residents at time of administration.

The inaccurate documentation of narcotic administration may have lea d other registered staff to believe that a narcotic was not administered.

Sources: Resident clinical record; interviews with ADOC and staff; Licensee policy of documentation of Narcotic and Controlled Medication Counts. [000687]

B) Rationale & Summary
According to licensee policy- VIII-E-10.20(a) Physician-NP Orders Guidelines, The second Nurse is responsible for writing his/her signature, status, date, and time indicating that the second check was done, following the same process as the first Nurse, and the information is accurate and transcribed to the appropriate requisitions correctly.

Medication reconciliation was completed by a registered staff for a resident. The second nurse check was missing on order review report.

The ADOC stated that the second nurse check was expected after the medication reconciliation was completed by the first nurse.

Failure to complete the second check by registered staff, puts the resident at risk to receive inaccurate treatment.

Sources: Resident clinical record; interviews with ADOC and staff; Licensee policy of Physician-NP Orders Guidelines.[000687]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.
The licensee failed to ensure that the home's continuous quality improvement committee was composed of every designated lead of the home.

Rationale and Summary
The home's ED/ CQI Lead indicated that the home's Stakeholders Quality Committee is their CQI committee.

The CQI committee, did not include every designated lead of the home.

Failure to include every designated lead of the home in the CQI committee was a missed opportunity for relevant interdisciplinary feedback pertaining to CQI initiatives.

Sources: Stakeholder Quality Advisory Committee Meeting minutes; Interview with the ED/ CQI Lead. [653]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.
The licensee failed to ensure that the CQI initiative report contained a written record of how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the members of the staff of the home.

Rationale and Summary
The home's ED/ CQI Lead indicated that the results of the survey were shared to the staff members during a town hall meeting.

The home's CQI initiative report did not include the abovementioned information and the dates when the results of the survey were shared to the members of the staff of the home.

Sources: The home's CQI initiative report; Interview with the ED/ CQI Lead. [653]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained a written record of how, and the dates when, the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were communicated to the members of the staff of the home.

Rationale and Summary
The home's ED/ CQI Lead indicated that the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were shared to the staff members during the operational planning day.

The home's CQI initiative report did not include the abovementioned information and the date when the actions taken by the home were shared to the members of the staff of the home.

Sources: The home's CQI initiative report; Interview with the ED/ CQI Lead. [653]