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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Public Report

Report Issue Date: January 2, 2025
Inspection Number: 2024-1412-0004
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Woodhall Park Community, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 17-20, 23-24, 30-31, 2024, and January 2, 2025

The following Critical Incident (CI) intakes were inspected:

- Intake #00126132, related to a respiratory outbreak
- Intake #00127326, related to alleged neglect
- Intake #00128415, and intake #00129459, related to injuries of unknown cause.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

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. 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 additional requirement under section 7.3 (b) of the Infection Prevention and Control (IPAC) Standard issued by the Director was followed. Specifically, the licensee has failed to ensure that all staff performed the IPAC skills required of their role, when their Hand Hygiene and Personal Protective Equipment (PPE) audits did not include the names of all staff audited.

Sources: the home's hand hygiene and PPE audits, IPAC Standard (2023) and an interview with the Director of Care (DOC).

Date Remedy Implemented: December 20, 2024

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 a resident's plan of care provided clear directions to the direct care staff related to one of the resident's activities of daily living (ADLs). Unclear directions on the resident's plan of care increased the risk the resident's risk for injury as staff may not provide appropriate interventions as required.

Sources: a resident's plan of care, home's investigation notes, and an interview with a Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed. Gaps in revising the resident's plan of care when their care needs for four ADLs changed, increased the resident's risk for injury when staff may not provide the appropriate interventions consistently.

Sources: a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the alleged neglect of a resident was immediately reported to the Director. By not informing the Director immediately, it limited their ability to respond to the incident in a timely manner if required.

Sources: a resident's clinical records, a critical incident report, and an interview with the DOC.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 has failed to ensure that a door leading to a non-residential area was kept closed and locked when not supervised by staff. When the door was left open, it could have resulted in residents accessing the non-residential area of the home.

Sources: Long-Term Care Homes (LTCH) Inspector's observations, and interviews with a Personal Support Worker (PSW), and the DOC.

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that a resident-staff communication system was easily accessed, seen and used by a resident at all times. The resident was at risk when they could not see and access their communication device if they needed to communicate with staff.

Sources: LTCH Inspector's observations, and an interview with a PSW.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident who was at risk of altered skin integrity received a skin assessment upon their return from the hospital. By not completing a skin assessment as required, increased the risk that the resident's areas of altered skin integrity may not be identified, and appropriate interventions may not be implemented in a timely manner.

Sources: a resident's clinical records, and interviews with an RPN and the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control 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).

The licensee has failed to ensure that the additional requirements of the IPAC Standard issued by the Director, section 6.1 and 6.3 related to PPE and section 10.2 (b) related to resident hand hygiene were followed.

Specifically, the licensee has failed to ensure that the required PPE was available and accessible for visitors and staff at the point of care when Droplet and Contact Precautions were in place and the hand hygiene product offered to a resident contained 70-90% alcohol. Gaps in the IPAC practices increased the risk of

microorganisms transmission and risks associated with improper use of hand hygiene products.

Sources: LTCH Inspector's observations, IPAC Standard (2023) and interviews with a PSW, IPAC Lead and the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The license has failed to ensure that the response provided to the person who made the complaint related to a resident's care and alleged neglect included contact information for the patient ombudsman under the Excellent Care for All Act, 2010. By not providing the complainant with the required information, it limited their ability to know their options.

Sources: a critical incident report, the home's complaint record, a resident's clinical records and interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that the response provided to the person making the complaint related to a resident care and alleged neglect included an explanation of what the licensee has done to resolve the complaint and the reason why the home believed the complaint was unfounded. By not providing the complainant with the required explanations, they may not be aware of the home's actions taken to resolve their concerns and reasons why their complaint was unfounded.

Sources: a critical incident report, the home's complaint record, a resident's clinical records and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(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;

The licensee failed to ensure that a documented record of the complaint related to a resident's care and alleged neglect that was kept in the home, included 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. Specifically, the complaint record did not include the date of the follow up with the complainant regarding their allegations of neglect and the type of actions taken, including the date of the actions, time frames for actions to be taken and any follow-up action required related to their additional care concerns.

Sources: the home's complaint record, and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(d) the final resolution, if any;

The licensee has failed to ensure that a documented record of a complaint related to a resident's care and alleged neglect the final resolution of the complaint. By not including the final resolution, it made it difficult to keep track of the complaint status.

Sources: the home's complaint record, and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee failed to ensure that a documented record of a complaint related to a resident's care and alleged neglect included every date on which any response was provided to the complainant and a description of the response. Specifically, the complaint record did not include the description of the response provided to the complainant in relation to their allegations of neglect and the date of any response provided and the description of the response related to the additional care related concerns.

Sources: the home's complaint record, and an interview with the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber. On two separate

occasions, the prescriber's directions for use related to a resident's as needed (PRN) medications were not followed, which increased the resident's risk for negative outcomes.

Sources: a resident's clinical records, and an interview with the DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health were followed. Specifically, respiratory outbreak recommendations related to PPE use for visitors and contact management for three symptomatic residents were not followed, increasing the risk of microorganisms transmission among residents, staff and visitors.

Sources: LTCH Inspector's observations, residents' clinical records, Outbreak Prevention and Control in Institutions and Congregate Living Settings (October 2024) and interviews with the IPAC Lead and other staff.