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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: December 16, 2024

Inspection Number: 2024-1477-0003

Inspection Type:
Complaint
Critical Incident

Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)

Long Term Care Home and City: Royal Rose Place, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12-14, and 18-21, 2024
The inspection occurred offsite on the following date(s): November 15, 2024

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00121772/CI #3049-000052-24, Intake: #00123793/CI #3049-000056-24 and Intake: #00129329/CI #3049-000072-24 were related to prevention of abuse and neglect
- Intake: #00122423/CI #3049-000053-24, Intake: #00122546/CI #3049-000054-24 and Intake: #00128456/CI #3049-000069-2 were related to prevention of abuse and neglect
- Intake: #00125934/CI #3049-000059-24 were related to falls prevention and management

The following complaint intake(s) were inspected:

- Intake: #00125895 was related to continence care, falls prevention and management, food, nutrition, and hydration, skin and wound prevention and management, and resident care and support services.

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
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: 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's plan of care was complied with.

Rationale and Summary
On specific date November 2024 it was observed in a resident's room that fall mats were in place on both sides of the resident's bed while the resident was not in bed.

The residents plan of care indicated that fall mats should only be in place when the resident is in bed.

Sources: Observation of the resident's room; resident plan of care; interview with staff.

Date Remedy Implemented: November 20, 2024

WRITTEN NOTIFICATION: Plan of care- Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care as set out in a resident's plan of care was documented.

Specifically, the provision of dietary interventions for the resident was not documented.

Rationale and Summary
The resident was assessed by the Registered Dietitian (RD) and the resident's plan of care was updated to include specific labelled items at breakfast and lunch meals due to increased nutrition needs.

Staff acknowledged that while the interventions were listed on the master diet list that is referred to for meal service, that the interventions were not documented when provided.

Failure to ensure that the provision of meal specific dietary interventions for the resident were documented may have lessened the level of accountability of the staff providing the interventions as ordered.

Sources: Residents clinical record; observation of master diet list; interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 has failed to protect residents #005, #002, #003, and #010 from physical abuse by residents #006, #002, #003, and #009.

Section 2 of Ontario Regulation (O. Reg.) 246/22, defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A) On specified date in October 2024, there was an incident between residents #005 and #006 which resulted in resident #006 causing an injury to resident #005. Resident #005 wound was treated, the residents were separated, and there have been no further concerns between them.

Failure to ensure that resident #005 was protected from abuse by resident #006, led to an injury.

Sources: Resident #005's progress notes, CI: 3049-000069-24, interviews with resident #005 and DOC.

Rationale and Summary
B) On a specified date in July 2024, an altercation occurred between residents #002 and #003 which resulted in injuries to both residents. The residents no longer reside on the same home area and there have been no further altercations between them.

Failure to ensure that residents #002 and #003 were protected from abuse led to injuries to both residents.

Sources: Progress notes and Wound Evaluations for residents #002 and #003; interviews with staff.

Rationale and Summary
C) On a specified date in July 2024, an altercation occurred between residents #009 and #010 which resulted in injuries to resident #010.

Failure to ensure that resident #010 was protected from abuse by resident #009, led to injuries to resident #010.

Sources: Progress notes and Wound Evaluations for resident #010; 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 an allegation of neglect was immediately reported to the Director.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director of the Ministry of Long-Term Care related to an allegation of neglect by staff to a resident. The home was advised of an allegation of neglect the day prior to notifying the Director. During an interview with Co-Director of Care it was acknowledged that the home did not immediately report the allegation of neglect.

Sources: CI #3049-000052-24 report; resident progress notes; interview with the Co-Director of Care.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had a fall that a post fall

assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
On a specified date in August 2024 a resident sustained three falls. It was confirmed during a review of the investigation notes and an interview with Co-Director of Care that appropriate post-falls assessments were not completed for the resident.

Failure to ensure assessments were conducted delayed appropriate care and treatment for the resident. The falls the resident sustained resulted in a transfer to hospital where it was confirmed that the resident had sustained an injury.

Sources: Investigation notes; record review of residents' assessment completed post-fall, the home's fall prevention and management policy, revised October 4, 2023; interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure that resident #001 received assistance from staff to manage and maintain continence as per their plan of care.

In accordance with O. Reg 246/22 s. 11(1)(b), the licensee is required as part of the

home's continence care and bowel management program, to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, and that it is complied with.

Specifically, staff did not comply with the home's "LTC Continence Care and Bowl Management- Program" (Program), last revised May 17, 2022. As per the home's Program, the staff was to be accurate and timely with documentation in Point of Care (POC) related to the level of support provided for the toileting schedule in place for the resident.

Rationale and Summary
The resident required total assistance from two staff members for continence care and was to be checked and changed as needed with use of an incontinence product.

On identified dates from June to August 2024, POC documentation indicated for several shifts that the level of support provided to the resident for changes and cleanses was "not applicable" and did not identify if it was completed. Staff confirmed that POC documentation should include the level of self-performance, and the level of support provided for toileting as per the resident plan of care and would be documented every shift.

There was a potential risk that when staff did not accurately document if the resident was checked and changed as per their plan of care, that the resident may not have received appropriate staff assistance.

Sources: Resident clinical record, documentation survey reports; interviews with staff; the home's "LTC Continence Care and Bowel Management- Program", last revised May 17, 2022.

WRITTEN NOTIFICATION: Pain Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to comply with the monitoring of the effectiveness of pain management interventions for a resident.

In accordance with O. Reg 246/22, s. 11 (1)(b), the licensee is required to ensure that the pain management program included monitoring of residents' responses to, and the effectiveness of, the pain management strategies, and that it was complied with.

Specifically, staff did not comply with the home's "Pain Management Program" that required registered staff to administer routine and/or as needed pain management interventions and to monitor and document its effectiveness.

Rationale and Summary
On specific date, there were non-verbal signs of pain identified for a resident. Nursing staff received orders from the physician to add a pain management intervention of a specific pain medication to support the residents pain control.

During a 13-day period, the pain management intervention was administered as ordered for the resident without documentation monitoring its effect on the resident.

There was a risk that the resident's pain management was not assessed for overall effectiveness when the home failed to monitor and document according to their program.

Sources: Interviews with staff; resident clinical records including the Electronic Medication Administration Record and progress notes; the home's " LTC Pain Management- Program", reviewed date June 3, 2022.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that the monitoring of behaviours for residents #002, #003 and #010 using the home's Dementia Observation System (DOS) was fully documented.

Rationale and Summary
A) DOS documentation was started for resident #002 following an altercation between another resident. Resident #002's DOS Data Collection Sheet was missing documentation.

Staff confirmed that DOS Data Collection sheet should be fully completed by staff.

Failure to fully complete the DOS posed a risk of resident #002's responsive behaviours not being identified that may have required follow-up.

Sources: Resident #002's DOS Data Collection Sheet; interview with staff.

Rationale and Summary
B) DOS documentation was started for resident #003 following an altercation between another resident. Resident #003's DOS Data Collection Sheet was missing documentation.

Staff confirmed that the resident's DOS Data Collection sheet was not fully completed and should have been.

Failure to fully complete the DOS posed a risk of resident #003's responsive behaviours not being identified that may have required follow-up.

Sources: Resident #003's DOS Data Collection Sheet; interview with staff.

Rationale and Summary
C) DOS documentation was started for resident #010 following an altercation involving another resident. Resident #010's DOS Data Collection Sheet was missing documentation.

Staff confirmed that DOS Data Collection sheet should be fully completed by staff.

Failure to fully complete the DOS posed a risk of resident #010 responsive behaviours not being identified that may have required follow-up.

Sources: Resident #010's DOS Data Collection Sheet; interview with staff.