Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2018	2018_655679_0024	007007-18, 016860-18, 017759-18	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

Long-Term Care Home/Foyer de soins de longue durée

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 27- 31, 2018, September 10-14, and 17-18, 2018.

The following intakes were inspected upon during this Critical Incident System inspection:

- Two logs submitted to the Director for an incident which caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status; and,

- One log submitted to the Director for misuse/misappropriation of a residents money.

A Complaint inspection #2018_655679_0025 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Restorative Care Coordinator, Registered Dietitian (RD), Culinary Manager, Staff Educator, Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping staff, Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, manufacturer instructions, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 49. (1), the licensee was required to ensure that 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.

Specifically, staff did not comply with the licensee's policy regarding "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised December 29, 2017, which was part of the licensee's Fall Prevention and Management Program.

A Critical Incident (CI) report was submitted to the Director on a specified date for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 fell and sustained an injury.

Inspector #679 reviewed resident #001's progress notes and identified that they were admitted to the home on a specified date. The progress notes identified that resident #001 had a specified number of falls prior to the fall resulting in injury.

A review of the policy entitled "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised December 29, 2017, identified that a resident who was at risk for falls was to be referred to a specific discipline. The policy further identified that the Restorative Care Coordinator or Physiotherapist will ensure that all residents were assessed by the specified discipline in a timely manner via post fall referral.

Inspector #679 reviewed the electronic progress notes and assessments for resident #009 and did not identify that the specified assessment was conducted for resident #009.

In an interview with RPN #103 they identified that a specified discipline's involvement would be "up to them" once the referral was sent to the Restorative Care Coordinator.

In an interview with Restorative Care Coordinator #109 they identified that a specified staff member conducts the particular assessments in the home a number of times per week. Restorative Care Coordinator #109 indicated the assessments were not typically done for a specified type of resident, and that they were seen on an as needed basis.

In an interview with the DOC they identified that the specified assessments were dependent on a number of factors. The DOC identified that the assessment should have been done for resident #001 after a specified fall.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the Falls Prevention and Management Program policy is complied with; specifically ensuring that residents who are at risk for falls are assessed as outlined in the policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (8) The licensee shall ensure that the provision and outcomes of the care set out in the care plan are documented. O. Reg. 79/10, s. 24 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment and reassessment.

A CI report was submitted to the Director on a specified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 fell and sustained an injury.

Inspector #679 reviewed resident #001's progress notes and identified that they were admitted to the home on a specified date. The progress notes identified that resident #001 had a specified number of falls prior to the fall resulting in injury.

A) Inspector #679 reviewed an electronic referral dated a specified date, which identified a comment directing staff to implement a specified mobility aid.

Inspector #679 reviewed resident #001's electronic care plan and identified that the implementation of the intervention was not added to the care plan until a number of days after the referral.

In an interview with PSW #105 they identified that staff would look in the resident's care plan for mobility interventions. PSW #105 indicated that they believed the resident used a specified mobility aid.

Together, Inspector #679 and Restorative Care Coordinator #109 reviewed resident #001's electronic referral dated a specified date, which advised staff to use a specific

mobility aid. Inspector #679 reviewed the electronic care plan which identified that the use of the mobility aid was updated in the care plan on a specified date. Restorative Care Coordinator #109 acknowledged the care plan should have been updated to reflect the change.

B) A review of the electronic care plan identified the use of a specific mobility aid.

Inspector #679 reviewed the electronic progress notes for the resident's admission and identified that resident #001 had arrived to the home with a specified mobility aid. The note identified that the resident had a different mobility aid with them, however, the resident's family member would bring the mobility aid home, as they would not need it.

In an interview with PSW #105 they indicated that resident #001's fall prevention interventions would be listed in their care plan. PSW #105 indicated that resident #001 used specified mobility aid, and that they did not use a different mobility aid.

In an interview with RPN #104 they identified that they did not recall resident #001 using a specified mobility aid.

Together, Inspector #679 and Restorative Care Coordinator #109 reviewed resident #001's electronic progress note, which identified that resident #001's family member removed the specified mobility aid. Restorative Care Coordinator #109 identified that the use of the specified mobility aid should have been removed from the care plan.

C) In separate interviews with PSW #105 and RPN #103 they identified a specified intervention as a fall prevention measure for resident #001.

Together, Inspector #679 and RPN #103 reviewed the electronic care plan. RPN #103 confirmed that the intervention was not listed in the care plan and identified it would be done as a nursing measure.

In an interview with RN #110 they identified that fall prevention interventions would be listed in the nursing care plan, as well as in the "tasks". RN #110 identified that if a resident had a specified intervention then it usually was listed in the care plan.

A review of the policy entitled "Resident Rights, Care and Services- Plan of Care- Plan of Care:" Revised March 13, 2018, identified that the "plan of care shall be reviewed and revised when the resident's care needs change, the care set out in the plan is no longer

necessary, or the care set out in the plan has not been effective". A review of the policy entitled "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised December 29, 2017, identified that staff were to ensure that the plan of care was updated to reflect the specifics to guide the provision of care.

In an interview with the DOC they identified that care plans were to be updated upon admission, as well as with any changes.

Together, Inspector #679 and the DOC reviewed the resident's plan of care and progress notes. The DOC identified that the care plan should have been updated to reflect that resident #001 did not use a specified mobility aid, that a specified intervention was completed for resident #001, and that resident #001 utilized a different mobility aid.

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CI report was submitted to the Director on a specified date for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 fell and sustained an injury.

A review of the progress notes on a specified date, identified particular interventions which were put in place as the plan to prevent further falls.

Inspector #679 reviewed a specified document for resident #001 and identified that documentation was missing on a number of occasions.

In an interview with PSW #105 they identified that resident #001 was at a specified level of risk for falls. PSW #105 confirmed that the specified document for resident #001 was used to document the intervention. PSW #105 confirmed that it would be the expectation that the documentation was complete.

In an interview with RPN #104 they identified that resident #001 was at a specified level of risk for falls, and that staff completed a specified intervention. Inspector #679 and RPN #104 reviewed the document for resident #001. RPN #104 confirmed that this form was used to document the intervention and that it would be the expectation that it was completed.

Together, Inspector #679 and the DOC reviewed the document for resident #001. The DOC confirmed it was the expectation that the documentation was completed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident on admission and on reassessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified on a specified date, resident #009 complained of pain to a specified area of their body. Resident #009 was later diagnosed with a particular diagnosis.

Inspector #679 reviewed the electronic progress notes which identified that resident #009 was being assisted in their mobility aid when a part of their body was injured.

Inspector #679 conducted a review of the home's internal investigation into the incident and identified a transcript of an interview with PSW #118 which identified that when they were assisting resident #009, the resident performed an action and then identified they experienced pain. An email between PSW #118 and the DOC regarding the incident identified that PSW #118 was not aware that resident #009 had a specified accessory for

their mobility aid.

Inspector #679 reviewed a "Memo" contained within the CI investigation file which identified a statement indicating that a specified accessory was not being used when assisting residents, and that this would be dangerous and can cause a resident to sustain an injury, if that resident decides to perform a specified action when being assisted.

In an interview with PSW #121 they identified that they had heard resident #009 complain of pain. PSW #121 identified they had asked the PSW what had happened and they replied that when they were assisting resident #009, the resident performed an action. PSW #121 identified that if staff were assisting a resident, that as long as they were not resistive they would use the specified accessory.

In an interview with RPN #116 they identified that they had assessed resident #009 after it was reported to them that resident #009 sustained a specified injury. RPN #116 identified that staff had notified them that "something may have happened" that could have cause an injury. RPN #116 identified that staff should be using a specified accessory when assisting residents.

In an interview with the DOC they identified that it would be the expectation that staff use a specified accessory when assisting residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 2nd day of October, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.