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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2018	2018_565647_0033	031213-18	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

JENNIFER BROWN (647)

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): December 3 - 5, 2018.

The following intake was completed in this Critical Incident System (CIS) Inspection related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted observation in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was received by the Director which indicated that resident #001 had caused physical harm to another resident.

The CIS report indicated that resident #001 had interacted with resident #002 when resident #002 had directed resident #001 to stop. The CIS report further indicated that resident #001 proceeded to grab resident #002, that resulted in an injury.

Inspector #647 reviewed the electronic plan of care, which indicated more than one intervention under more than one focus for a provision of care resident #001 was to receive.

During interviews with direct care staff members #100, #104, and Registered staff

member #101 they all indicated that the plan of care was reviewed by staff to ensure the care delivery on a day to day basis was delivered to ensure the needs of the residents were met. The staff members further indicated that staff were to review the plan of care to ensure they were aware of the interventions.

Together, Inspector #647 and Registered staff member #103 reviewed resident #001's most recent plan of care. Registered staff member #103 identified that the plan of care did not provide staff with clear direction as the current plan of care contained three different interventions related to a type of provision of care resident #001 was to receive. [s. 6. (1) (c)]

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

A CIS report was received by the Director, which indicated that resident #001 had caused physical harm to another resident. For further details regarding the CIS report, please refer to WN #1, paragragh 3.

Inspector #647 reviewed the electronic plan of care, which indicated the requirement of a specific intervention.

A review of a specific document ("tool"), indicated that the provision of care for resident #001 had not been documented on several occasions.

During interviews with direct care staff members #100, #104, and Registered staff member #101 they all indicated that the specific tool was used to document and monitor resident #001.

Together, Inspector #647 and Registered staff member #103 reviewed the specific tool for resident #001 and confirmed that the required intervention had not been documented. [s. 6. (9) 1.]

3. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary

A CIS report was received by the Director which indicated that resident #001 had caused physical harm to another resident. For further details regarding the CIS report, please

refer to WN #1, paragraph 3.

A review of the progress notes for resident #001 indicated that there had been previous incidents where resident #001 was involved in an interaction with other residents on five previous occasions.

Inspector #647 reviewed the electronic plan of care which indicated there had not been any care plan focus for resident #001's interactions until a later identified date when resident #003 reported that resident #001 had caused them harm.

During interviews with direct care staff members #100, #104, and Registered staff member #101 they all indicated that the plan of care was reviewed by staff to ensure the care delivery on a day to day basis was delivered to ensure the needs of the residents were met. The staff members further indicated that staff reviewed the plan of care to ensure they were aware of the interventions.

Together, Inspector #647 and Registered staff member #103 reviewed resident #001's most recent plan of care. Registered staff member #103 identified that the plan of care did not contain any focus related to the interactions until after the third type of interaction. Registered staff member #103 further indicated that the plan of care should have been revised after the first type of interaction. [s. 6. (10) (b)]

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 to ensure the plan of care set out clear directions to staff and others who provide directions to staff and others who provide direct care to the resident, to ensure that the provision of care was documented as set out in the plan of care and to ensure that resident's are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
i) Abuse of a resident by anyone
ii) Neglect of a resident by the licensee or staff, or
iii) Anything else provided for in the regulations.

A CIS report was received by the Director which indicated that resident #001 had caused physical harm to another resident. For further details regarding the CIS report, please refer to WN #1, paragraph 3.

A review of the progress notes for resident #001 indicated that there had been previous incidents of abuse towards other residents. The progress notes indicated that on an identified date, resident #003 had reported to staff that they had been injured by resident #001. Staff had not witnessed this; however, staff had witnessed resident #001's interactions towards resident #003. It had been further documented that resident #003 was complaining of pain after the incident.

During an interview, the Administrator indicated that this incident had not been investigated as the allegation had not been witnessed by staff. The Administrator acknowledged that resident #003 had been injured and had been experiencing pain as a result of the alleged abuse, and that it should have been investigated as required by the legislation. [s. 23. (1) (a)]

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 to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

i) Abuse of a resident by anyone
ii) Neglect of a resident by the licensee or staff, or
iii) Anything else provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

A CIS report was received by the Director which indicated that resident #001 had caused physical harm to another resident. For further details regarding the CIS report, please refer to WN #1, paragraph 3.

A review of the progress notes for resident #001 indicated that there had been previous incidents of abuse towards other residents. The progress notes indicated that resident #003 had reported to staff that they had been injured by resident #001. Staff had not witnessed this; however, staff had witnessed resident #001's interactions towards resident #003. It had been further documented that resident #003 was complaining of pain after the incident.

During an interview, the Administrator indicated that this incident had not been reported to the Director as the allegation had not been witnessed by staff. The Administrator acknowledged that resident #003 had been injured and had been experiencing pain as a result of the alleged abuse, and that it should have been reported to the Director as the incident resulted in harm to resident #003. [s. 24. (1)]

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 to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm,
3. Unlawful conduct that resulted in harm or risk of harm to a resident,
4. Misuse or misappropriation of a resident's money,
5. Misuse or misappropriation of funding provided to a licensee under the Act, to be implemented voluntarily.

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.