Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 16, 2020	2020_745690_0001	022161-19, 000424-20	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

TRACY MUCHMAKER (690)

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): January 6-10, 2020.

The Following intake(s) were inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that the home submitted to the Director regarding a missing resident with an injury;
-One log, which was related to a critical incident that the home submitted to the Director regarding a disease outbreak.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Director of Care, Education Coordinator (EC), Volunteer Coordinator (VC), Housekeeping Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, staff personnel files, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Director on an identified date, related to an incident in which resident #001 sustained an identified injury and was transferred to the hospital.

Inspector #690 conducted a review of resident #001's electronic progress notes and identified a progress note, dated three months prior to the inspection, that indicated that the resident had fallen and had an identified intervention in place to prevent falls.

A review of resident 001's electronic care plan that was in place at the time of the inspection identified a focus for risk of falls and identified the resident's level of risk for falling. The care plan indicated that there were identified interventions in place to prevent falls. The care plan further indicated that two of the identified interventions were to be in place when the resident was in bed.

Inspector #690 observed resident #001 in their bed on the first two days of the inspection, and identified that two of the identified fall prevention interventions that were indicated on the care plan were not in place.

In an interview with Personal Support Worker (PSW) #103, they indicated that resident #001 was at risk of falling and had been having falls while attempting to perform a specified activity of daily living (ADL). PSW #103 indicated that resident #001 did not have one of the identified interventions in place, and that they had not recalled ever seeing the second identified intervention in the resident's room.

In an interview with Registered Nurse (RN) #104, they indicated that resident #001 was at risk of falling and had a history of falls. Together RN #104 and Inspector #690, reviewed resident #001's fall prevention interventions on the care plan, and RN #104 identified that the resident was to have two identified interventions in place when the resident was in bed. Together RN #104 and Inspector #690 observed resident #001 in their bed and RN #104 identified that the two identified interventions were not in place. RN #104 indicated that care was not provided to resident #001 as specified in the care plan and that it should have been.

In an interview with the Director of Care (DOC), they indicated that resident #001 was at risk of falling and had a history of falls. Together the DOC and Inspector #690 reviewed resident #001's fall prevention interventions on the care plan and the DOC indicated that

the resident was to have the two identified interventions in place. The DOC indicated that if the two identified interventions were not in place, then care was not provided as specified in the care plan and that it should have been. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received training in the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents, before performing their responsibilities.

A CI report was submitted to the Director on an identified date, for an incident in which resident #001 sustained an identified injury and was transferred to the hospital. Please see Written Notification (WN) #1 for details.

The Inspector reviewed the home's investigation notes related to the incident involving resident #001, and viewed a document titled "Orientation Checklist -LTC General Orientation Checklist-Day 1". The document indicated that Housekeeper #106's date of hire was one week prior to the above mentioned incident. The orientation checklist document indicated that Housekeeper #106, received training for home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents, after the incident occurred.

The Inspector reviewed the personnel file for Housekeeper #106 and viewed an additional orientation checklist from an external agency. The checklist included a list of training provided and was initialed by Housekeeper #106. The document did not include reference to training on the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents. There were no dates to indicate when Housekeeper #106 had completed the training.

In an interview with Housekeeper #106, they indicated that their date of hire was approximately one week prior to the incident and they had been trained by the Housekeeping Supervisor for the areas listed on the orientation checklist from the external agency. Housekeeper #106 indicated that they had received the training and signed the checklist prior to performing their responsibilities, but could not recall the exact dates of the training. Housekeeper #106 further indicated that they completed the education on the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents after the incident occurred and did not recall receiving training on those areas prior to attending the education session. [s. 76. (2)]

2. The Inspector reviewed the personnel file for Housekeeper #113, and viewed an

orientation checklist from the external agency. The checklist included a list of training provided and was initialed by Housekeeper #113. The document did not include reference to training on the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents. There were no dates to indicate when Housekeeper #113 had completed the training. The orientation checklist document indicated that Housekeeper #113, received training for home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents, the day after the incident occurred. The Inspector viewed an additional document in the personnel file that indicated that Housekeeper #113's date of hire was approximately six weeks prior to receiving the training.

In an interview with Housekeeper #113, they indicated that they could not recall their exact date of hire, however knew it was sometime in the month before the incident occurred. Housekeeper #113 indicated that they had been trained by the Housekeeping Supervisor on the date of hire for the areas listed on the orientation checklist from the external agency prior to performing their responsibilities. Housekeeper #113 further indicated that they attended an education session on an identified date after the incident and completed the education on the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents and did not recall receiving training on those areas prior to that. Housekeeper #113 indicated that they had also completed some training on the home's zero tolerance for abuse policy on the online training system, but that they did not complete it until about two or three weeks after starting to work as they had an issue with logging into the system. [s. 76. (2)]

3. The Inspector reviewed the personnel file for Housekeeper #115, and viewed an orientation checklist from the external agency. The checklist included a list of training provided and was initialed by Housekeeper #115. The document did not include reference to training on the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents. There were no dates to indicate when Housekeeper #115 had completed the training. The Inspector viewed an additional document titled "Orientation Checklist -LTC General Orientation Checklist-Day 1". The orientation checklist document indicated that Housekeeper #115, received training for home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, and the home's policy to minimize the restraining of residents, after the incident occurred.

In an interview with Housekeeper #115, they indicated that they could not recall their exact date of hire. Documents in Housekeeper #115's personnel file indicated that they had been employed at the home for approximately seven months. Housekeeper #115 indicated that they had been trained by the Housekeeping Supervisor for the areas listed on the orientation checklist from the external agency prior to starting their duties. Housekeeper #115 further indicated that they attended an education session after the incident occurred and completed the education on the home’s mission statement, the home’s policy to promote zero tolerance of abuse and neglect of residents, and the home’s policy to minimize the restraining of residents and did not recall receiving training on those areas prior to that date.

In an interview with the Housekeeping Supervisor, they indicated that the housekeeping employees work for an external agency but that the staff work regularly in the home. The Housekeeping Supervisor indicated that they were responsible for providing orientation and training to the new housekeeping employees. Together, the Housekeeping supervisor and the Inspector reviewed the orientation checklists from the external agency for Housekeeper #106, Housekeeper #113, and Housekeeper #115, and the Housekeeping Supervisor indicated that they had completed the orientation checklist with the housekeepers but not recall the exact dates that the checklist was completed. The Housekeeping supervisor indicated that they went over the areas on the checklist prior to the employees performing their responsibilities and signed off on the checklist when it was filed in the employee files. The Housekeeping Supervisor indicated that they did not provide training on home’s mission statement, the home’s policy to promote zero tolerance of abuse and neglect of residents, and the home’s policy to minimize the restraining of residents and that it was not included on the external agency's orientation checklist. The Housekeeping Supervisor indicated that all three of the Housekeepers completed training on the above mentioned areas after the incident occurred, which was after the employees started performing their responsibilities.

In an interview with the Administrator, they indicated that the home would provide training and orientation for Housekeeping and Dietary staff, which were both contracted service providers, who work regularly in the home if there was a orientation session scheduled. The Administrator indicated that if there was not an orientation session booked then the respective Supervisor for the department would complete it. Together the Administrator and the Inspector reviewed the orientation checklists for Housekeeper #106, Housekeeper #113, and Housekeeper #115, and the Administrator indicated that the housekeepers did not receive training on the home’s mission statement, the home’s policy to promote zero tolerance of abuse and neglect of residents, and the home’s policy

to minimize the restraining of residents prior to performing their responsibilities and that they should have. [s. 76. (2)]

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 all staff receive training on the home's mission statement, the home's policy to promote zero tolerance for abuse and neglect of residents, and the home's policy to minimize the restraining of residents, before performing their responsibilities, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Upon entering the home on January 6, 2020, Inspector #690 was informed that the home had a communicable disease outbreak on a specific home area (HA) and that the outbreak had been declared the previous month.

The Inspector reviewed the Critical Incident System (CIS) reporting portal and could not find a CI report for the communicable disease outbreak.

In an interview with the DOC and the Co-Director of Care (Co-Doc), they indicated that the DOC had initiated the CI report for the communicable disease outbreak on the day the outbreak was declared, but that they were not able to submit the CI report. The DOC indicated that they were unsure why they were not able to submit the report and that they had not called the Ministry of Long Term Care (MOLTC) after hours reporting line to notify the Director of the outbreak or attempted to call the technical support number for assistance with submitting the report. The Co-Doc logged into the CIS reporting portal and showed the Inspector the CI report that was initiated the previous month, that was in a saved draft format. The Co-Doc indicated that they did not know that the Director would not be made aware of the outbreak if the CI report was not submitted. [s. 107. (1) 5.]

2. Upon entering the home on January 6, 2020, the Inspector was informed that another HA was in a different communicable disease outbreak and that the outbreak had been declared prior to the start of the inspection.

The Inspector reviewed the CIS reporting portal and could not find a CI report for the communicable disease outbreak. The Inspector could not locate an after hours report to indicate that the home notified the Director through the MOLTC after hours reporting line.

The Inspector viewed a document titled “Outbreak Line Listing Form”. The document indicated that the outbreak was declared prior to the start of the inspection, and included an outbreak number and case definition.

In an interview with RN #112, they indicated that they were the Charge Nurse (CN) on the HA on a specific date, when they were made aware that two residents had symptoms of a specific illness and that they had been monitoring them. RN #112 indicated that a third resident began showing signs of a specific illness after breakfast and that they had notified the Public Health Unit. RN #112 further indicated that they were advised by the on-call staff member from the Public Health Unit that the HA was being declared in outbreak, and that an outbreak number and case definition would be sent to the home. RN #112, indicated that they had not reported the outbreak to the MOLTC after hours reporting line, and was unsure if the DOC had called the MOLTC after hours reporting line.

In an interview with the DOC and the Co-Doc, they indicated that the Charge Nurse had contacted the Public Health agency, as there were three residents that were exhibiting symptoms of an illness. The DOC indicated that they were made aware on that specific

date, that Public Health had declared an outbreak on the HA, and had issued an outbreak number and a case definition. Both the DOC and Co-Doc indicated that they had not notified the Director of the outbreak immediately as they thought they had until the next business day to report the outbreak. The Co-Doc further indicated that upon returning to work on the next business day, they provided updated information to the Public Health agency regarding the resident's symptoms and that the Public Health agency changed the status of the outbreak to a suspected outbreak and therefore they did not submit a CI report upon returning to work.

In an interview with the Administrator they indicated that the home had been in an outbreak since the previous month, and were not aware if the home had submitted a CI report to notify the Director of the outbreaks at the time the outbreaks were declared by the Public Health agency. The Administrator further indicated that the home should have notified the Director of the outbreaks immediately. [s. 107. (1) 5.]

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 Director is immediately informed in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A CI report was submitted to the Director on an identified date, for an incident in which resident #001 sustained an identified injury and was transferred to the hospital. Please see Written Notification (WN) #1 for details.

Inspector #690 conducted a review of resident #001's electronic progress notes and identified an incident note documented on the day of the incident, that described the incident and indicated that the resident was injured and was being transferred to the hospital. A further review of the progress notes identified nine progress notes documented in the eight months prior to the incident and one progress note documented after the incident that indicated that resident #001 had an identified responsive behaviour.

Inspector #690 conducted a review of resident #001's care plan that was in place at the time of the incident and could not locate a focus for the identified behaviour or any interventions to manage the behaviour. A review of the care plan that was in place at the time of the inspection identified a focus for the identified responsive behaviour. The Inspector could not find any interventions related to the identified responsive behaviour.

In separate interviews with PSW #103, PSW #105, and PSW #107, they indicated that resident #001 had a history of having the identified responsive behaviour. PSW #103,

PSW #105, and PSW #107 indicated that would utilize the care plan or Kardex on Point of Care (POC) to find information on a resident's responsive behaviours and what interventions were in place.

In an interview with RN #104, they indicated that resident #001 had a history of the identified responsive behaviour and had observed the responsive behaviour in the past. RN #104 indicated that they would utilize the care plan on Point Click Care (PCC) to find out what responsive behaviours a resident had and what interventions were in place. Together, Inspector#690 and RN #104 viewed resident #001's care plan that was in place at the time of the incident and RN #104 indicated that there was no focus or interventions on the care plan related to the identified responsive behaviour and that there should have been.

In an interview with the DOC they indicated that they did not consider that resident #001 had the identified responsive behaviour based on what they were aware of. Together, the Inspector and the DOC reviewed the above mentioned progress notes on PCC and the DOC indicated that based on the review of the progress notes, they would agree that resident #001 had been exhibiting the responsive behaviour prior to the incident.The Inspector and the DOC reviewed the care plan that was in place at the time of the incident and the DOC identified that the care plan did not include a focus or interventions for the identified responsive behaviours and that it should have. The Inspector and the DOC reviewed the care plan that was in place at the time of the inspection and the DOC identified that there was a focus on the care plan for the identified responsive behaviour but that there were no interventions on the care plan until a staff member added them after being interviewed by the Inspector. [s. 53. (4) (b)]

2. Inspector #690 conducted a review of resident #002's progress notes and identified three progress notes that were documented over a period of three months prior to the inspection, that indicated that the resident was exhibiting an identified responsive behaviour.

A review of resident #002's electronic care plan in place at the time of the inspection identified a focus for the identified responsive behaviour that was added to the care plan three days before the start of the inspection.

In separate interviews with PSW #105, and PSW #107, they indicted that resident #002 had a history of the identified responsive behaviour. The PSW's indicated that they would find information on a resident's responsive behaviours and interventions on the care

plan.

In an interview with RN #108, they indicated that resident #002 had a history of the identified responsive behaviour. RN # 108, indicated that they would check the care plan on PCC to find information on a resident's responsive behaviours and what interventions were in place. Together, RN#108 and the Inspector reviewed the resident's care plan and RN #108 identified that the focus and interventions for the identified behaviour was added to the care plan the previous week, and that it should have been included in the care plan prior to that date as the resident had the responsive behaviour for some time.

In an interview with the Volunteer Coordinator, they indicated that resident #002 had a history the responsive behaviour for approximately 10 months, and that they had added the focus and interventions to the care plan approximately a week ago after conducting a review of all residents in the home that had the identified responsive behaviours after the incident occurred. The Volunteer Coordinator indicated that prior to them updating the care plan, resident #002's care plan did not include a focus or interventions for the identified responsive behaviour and that it should have.

In an interview with the DOC, they indicated that they were not aware that resident #002 had a history of the identified responsive behaviour. Together the DOC and the Inspector reviewed resident #002's care plan and the DOC identified that the focus and interventions for the identified responsive behaviours were added to the care plan approximately a week ago, and that it should have been included on the care plan prior to that if the resident had the identified responsive behaviour prior to that.

This finding of non-compliance is further evidence to support the Compliance Order (CO) #002, related to section (s). 53. (4) of the Long-Term Care Homes Act (LTCHA) 2007, that was issued to the licensee on November 26, 2019, during Critical Incident Inspection #2019_746621_0034, which has a compliance due date of January 10, 2020. [s. 53. (4) (b)]

Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.