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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Mar 14, 2022	2022_899609_0004	013404-21, 015236-21, 000539-22, 001425-22	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

CHAD CAMPS (609), JENNIFER NICHOLLS (691)

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): February 7-11 and February 14-18, 2022.

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

-One intake related to a medication error,

-Two intakes related to allegations of staff to resident neglect, and

-One intake related to a fall of a resident.

A Follow up inspection #2022_899609_0005 and a Complaint inspection #2022_899609_0003 were completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents and their families, the Administrator, Regional Manager, Administrative Assistant, Scheduler, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Nurse Practitioner (NP), Infection Prevention Program (IPAC) Lead, Housekeeping staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Screeners.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care to residents, observed staff and resident interactions, reviewed relevant health care records, audits, compliance action plans, staffing schedules, internal investigation notes as well as the home's relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) A resident had an injury that caused altered skin integrity. An initial skin assessment was not fully completed until 12 days later.

b) After returning to the home, registered staff identified that a resident had two areas of potential altered skin integrity.

The Inspector found that no registered staff assessed one of the resident’s potential areas of altered skin integrity, while the other area was assessed using the home’s skin assessment four days later, which found that the resident’s altered skin integrity had worsened.

Registered staff verified that the resident should have been assessed when they returned to the home using the home's skin assessment.

The home’s failure to ensure that the resident received a skin assessment by a member of the registered nursing staff, presented actual risk of harm to the resident whose altered skin integrity deteriorated.

Sources: a CIS report, a resident’s electronic/paper health care records, the home’s internal investigation, the home’s policy titled “Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program” last reviewed January 1, 2020, interviews with a Co-DOC and other staff. [s. 50. (2) (b) (i)]

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 residents who exhibit altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision-Makers (SDMs) for two residents were immediately notified of the results of their investigations required under subsection 23 (1) of the Act.

The home became aware of allegations of neglect of two residents. The home completed investigations into the allegations of neglect of the residents, yet the residents' health care records found no mention that their SDMs were made aware of the results of the home's investigations as required by the home's policy.

A Co-DOC and the home's Administrator verified that the residents' SDMs were not notified of the results of the home's internal investigations and should have been.

The home's failure to notify the residents' SDMs of the results of the home's internal investigation presented minimal risk to the resident.

Sources: two CIS reports, two residents' electronic/paper health care record, the home's internal investigations, the home's policy titled "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect – Zero-Tolerance Policy for Resident Abuse and Neglect" version two, effective date September 16, 2013, interview with a Co-DOC and Administrator.
[s. 97. (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 that the SDMs for residents are immediately notified of the results of their investigations required under subsection 23 (1) of the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

In the middle of a medication administration, Registered Nurse (RN) staff left a resident alone with multiple medications which the resident never consumed.

RN staff left the resident alone with their medications which was against the home's policy. And, having no knowledge of how much of the medications the resident had consumed, documented that all the medications were fully administered in the resident’s electronic Medication Administration Record (eMAR).

The home’s Administrator and RN staff verified that RN staff should not have left the resident alone with their medications and should have accurately documented their administration.

The home’s failure to ensure that the resident's medications were administered as specified by the prescriber presented minimal harm to the resident.

Sources: a CIS report, a resident’s eMAR, a resident’s electronic/paper health care records, a resident’s Physician Medication Review, the home’s internal investigation, the home's policy titled "Resident Rights, Care and Services - Medication Management - Administration of Medications including as PRN Medications" last revised June 30, 2020, interviews with the Administrator and other staff. [s. 131. (2)]

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.

During a medication administration, RPN staff administered more than 10 times the amount of a medication to a resident.

Without conducting an independent double check on the dosage by two registered staff as the home's policy indicated, RPN staff administered the wrong dose of the drug to the resident. This occurred because they misread the closely printed text on the resident's eMAR pop-up reminder.

The home’s failure to ensure that the resident was administered a medication as specified by the prescriber presented minimal harm to the resident.

Sources: a CIS report, a resident’s electronic/paper health care records, the home’s internal investigation, the home’s policy titled “Resident Rights, Care and Services – Medication Management – Diabetic Care” last reviewed November 1, 2019, interviews with a Co-DOC and other staff. [s. 131. (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 that drugs are administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 18th day of March, 2022

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

Original report signed by the inspector.