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
Mar 14, 2022	2022_899609_0003	019599-21, 019777-21	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): February 7-11 and February 14-18, 2022.

The following intake was inspected upon during the Complaint inspection:

-One intake related to care concerns and allegations of neglect of a resident.

A Critical Incident System inspection #2022_899609_0004 and a Follow up inspection #2022_899609_0005 were conducted currently 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, internal investigation notes as well as the home's relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 Substitute Decision-Maker (SDM) for a resident had been provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's health care records described how they had continued to receive various new treatments for an area of altered skin integrity. Documentation indicated that circumstances contributed to the resident's deteriorating altered skin integrity.

The Inspector could not identify any progress notes to indicate that the resident's SDM had been notified of the circumstances contributing to the resident's deteriorating altered skin integrity. The SDM was not made aware of the current state of the altered skin integrity or the treatment being provided.

A Co-Director of Care (Co-DOC) verified that there was no documentation to indicate that the resident's SDM had been informed of the deterioration of the altered skin integrity.

The home's failure to ensure that the resident's SDM had been provided the opportunity to participate fully in the plan of care related to altered skin integrity, presented a minimal risk of harm to the resident.

Sources: the home's policies titled "Resident Rights, Care and Services-Plan of Care (Care Planning) and "Resident Rights, Care and Services -Required Programs-Skin and Wound Care -Program" last revised October 2018, a resident's health care records, Nurse Practitioner/Physician orders, wound assessments, the electronic Treatment Administration Record (eTAR), the home's internal investigation notes, interviews with a Co-DOC and other staff. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident’s plan of care indicated they were to be provided with a continence product as per the resident’s worksheet. A review of the home’s worksheet indicated the resident was to have a specific continence product provided for all shifts. Personal Support Worker (PSW) staff verified that the resident required a specific continence product at all times but acknowledged they had witnessed incorrect continence products applied to the resident.

A review of the home’s investigation discovered on multiple occasions that the incorrect continence products were applied to the resident.

A Co-DOC verified that the resident’s care was not provided as specified in their plan.

The home’s failure to ensure that the resident had been provided the correct continence product presented minimal risk of harm to the resident.

Sources: the home's policy titled "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management- Program" last revised February 2018, and "Resident Rights, Care and Services-Plan of Care (Care planning)" last revised September 2019, a resident's health care records, internal investigation documents, interviews with Co-DOCs and other staff. [s.6 (7)] [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 the SDM for a resident is provided the opportunity to participate fully in the development and implementation of the resident's plan of care and that the care set out in the resident's plan of care is provided 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. 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.
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.
3. Unlawful conduct that resulted in harm or a 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 this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A resident's SDM sent correspondence to the home which alleged neglect of the resident.

The Administrator verified that a critical incident was not submitted to the Director and the allegation should have been reported immediately.

Sources: The home's internal investigation notes, correspondence from a resident's SDM, a resident's health care records, the home's policy titled "Reporting and Complaints policy- Critical Incident Reporting" last revised March 20, 2020, interview with the Administrator and other staff. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The home’s internal investigation records identified multiple complaints were submitted to the home related to a resident's care. However, the Inspector found no information related to the complaints in the home’s complaint log.

The Administrator verified that the complaint log was missing the complaints related to a resident's care concerns.

The home's failure to keep a documented record of all verbal and written complaints presented minimal risk of harm to the resident.

Sources: The home's complaint logs, investigation notes, the home's policy titled “Reporting and Complaints-Concerns and Complaints process” last revised June 2021, interviews with the Administrator and other staff. [s. 101. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written records were kept up to date at all times.

RN staff documented on two occasions that a resident's SDM reported that a specific type of care was not provided to the resident. However, documentation indicated that PSW staff had provided the resident with the care. A review of the home's internal investigations were conducted with Co-DOCs, who verified that PSW staff did not provide the care that was documented. The Co-DOC(s) indicated that the resident's records were not documented accurately and therefore not up to date.

Sources: the home's policy titled "Job Description" "Title- Personal Support Worker", last revised January 13, 2020, a resident's health care records, the home's internal investigation notes, including emails, interviews with Co-DOCs, Director of Care (DOC) and other staff. [s. 231. (b)]

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.