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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2013	2013_157210_0002	T-00454-12, T-2183-12	Complaint

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, 18, 19, 21 and March 25, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Staff, Director of Care, Assistant Director of Care, Food Services Supervisor, Restorative Care Program Coordinator, Physiotherapist

During the course of the inspection, the inspector(s) reviewed residents' charts, home policies

The following Inspection Protocols were used during this inspection:
Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s.6.(7)]
The review of documentation and staff interview indicated that on Mar 24, 2013 Resident #2 had an incident of yelling out derogatory statements, accusing and threatening staff, lowering self to floor, shifting in wheelchair, being restless. The behavioral support care plan specified: to avoid arguing, reasoning, correcting or showing that she/he was upset, as that would actually reinforce the behavior. The interview with Staff #1 indicated that on March 24, 2013 during dinner time staff didn't provide the care to the resident as specified in the plan. Staff #1 responded to the resident that she was going to call the police if the resident continued to threaten staff since that was considered as abuse towards staff. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, where the condition or circumstances exist, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.[R.49.(2) The record review indicated that on February 24, 2012, at 7:10am, Resident #1 had a fall and resident was found laying beside the bed. Resident was sent to hospital because of pain in the left leg. Resident sustained left femoral neck fracture that was operated on February 26, 2012. After this, resident had two subsequent falls, one on April 26, 2012 at 18:15 and another one on July 22, 2012 at 19:05. The second one resulted in transfer to hospital for assessment. The interview with staff and review of Fall incident notes revealed that the post-fall assessment on April 26, 2012 was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter. [R. 68. (2) (e) (I)]
The staff interview and review of documentation indicated that the weight of the Resident #3 was not taken in two instances (August and December) during 2012. The weight of the Resident #4 was not taken in January 2013 and July 2012. The weight of Resident #2 was not taken in March 2012, April 2012, May 2012, August 2012, December 2012 and January 2013. [s. 68. (2) (e) (i)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months.

The review of the documentation and interview with Staff # 3 indicated that the weight of the Resident #2 was 73.2kg in February 2012 and 67.2 kg in June 2012. The weight change of 6kg was not assessed using an interdisciplinary approach, action was not taken and outcomes evaluated. [s. 69.]

Issued on this 9th day of April, 2013

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