Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 7, 2024

Inspection Number: 2024-1098-0002

Inspection Type:
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Owen Hill Community, Barrie

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2024.06.07 09:29:31 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15-18, 22-25, 2024

The following intake(s) were inspected:

- Intake #00107113, CI #2584-000002-24 - related to a fall of a resident resulting in injury
- Intake #00112740, CI #2584-000007-24 - related to an outbreak

The following intake(s) were completed in this inspection:

- Intake #00108506, CI #2584-000006-24 - related to an outbreak

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions for staff and others who provided direct care to the resident.

Rationale and Summary
The Occupational Therapist (OT) completed an assessment for a resident and recommended a full tilt wheelchair. Two months later, the resident received this wheelchair. The resident's care plan was not updated to indicate that they had a tilt wheelchair or instructions on how or when to tilt the wheelchair.

The homes Personal Assistance Services Devices (PASD) Policy indicates the decision to use a PASD, such as a tilt wheelchair, should be documented in the residents record, including the rationale for use, and the residents care plan should be updated with the intervention and monitoring of the PASD.

During the inspection the Fall Lead indicated that the resident did not have a tilt wheelchair. They stated there was no order or documentation that there was a tilt wheelchair in place for the resident.

Three frontline staff members indicated that the resident had a tilt wheelchair and that the resident was to be tilted when they were in their wheelchair.

Three months after receiving their wheelchair, the resident sustained injuries from a fall. The Executive Director stated the resident's wheelchair was not tilted.

When the resident's plan of care did not set out clear directions for use of their tilt wheelchair, it was unclear when or how the tilt wheelchair was to be used.

Sources: A resident's clinical records, Falls Huddle documentation, Align invoice, Proof of Delivery; PASD Policy VII-E-10.10 last revised 12/2023; Interviews with staff.

[741126]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure a resident received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital.

Rationale and Summary
A resident had a fall which resulted in an injury and required transport to hospital. Hospital notes from the same day stated the resident had multiple areas of altered skin integrity.

The resident returned to the long-term care home with dressings in place and an open injury. The resident did not receive a head to toe assessment when they returned from hospital or any clinically appropriate skin assessments for their areas of altered skin integrity.

The DOC stated a head-to-toe assessment should have been completed on the resident after their return from hospital, and if any wounds were identified in this head-to-toe assessment, subsequent skin and wound assessments should have been completed for any open areas.

By failing to complete a head to toe assessment on the resident upon return from hospital, it put the resident at risk of not having their wounds documented, monitored, or treated.

Sources: A resident's clinical records; Interviews with staff.

[741126]

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care

s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Develop and implement a process to ensure that when trends are identified in the monthly falls huddle, new approaches are developed and implemented to address these trends. In addition, if any interventions or approaches for falls prevention are discussed at falls huddles, there is a timeframe for them to be implemented or a reason the intervention is not feasible. This process should be documented.
- Complete and maintain a record of audits on the next two monthly falls huddles that are conducted on the third floor showing what interventions or approaches were discussed and if those interventions or approaches were implemented. Include the timeframe in which these intervention or approaches were implemented or a plan of action if these approaches were not implemented and did not have a documented reason they were not feasible.

Grounds
The licensee has failed to ensure that when the care set out in the plan was not effective for a resident that different approaches were considered in the revision of the plan of care.

Rationale and Summary
A resident had four falls from a specific device in an 11 week period.

The resident had two falls from a specific device and their plan of care related to falls was revised to remove interventions.

After these falls, a fall huddle was conducted where it was identified that it was a trend for the resident to fall from a specific device. It was discussed that the resident may benefit from a specific intervention. The plan of care was not updated at this time.

The resident had a third fall from the same device. Their plan of care for falls prevention was not updated at this time.

The resident had a fourth fall from the specified device. At this time the residents plan of care was updated to identify that the resident was at high risk for falls related to using this device and provided more interventions to prevent falls. The intervention that was discussed at the previous fall huddle was now followed up on with the Nurse Practitioner.

The Falls Lead indicated that the implementation of the intervention identified in the fall huddle should have been more timely.

When different approaches for falls prevention and management were not tried, this may have contributed to the resident's falls and subsequent injuries.

Sources: a resident's clinical records; CI #2584-000002-24; Interview with Falls lead #110.

[741126]

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Central West District
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This order must be complied with by
July 19, 2024

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

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Waterloo, ON, N2V 1K8
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.