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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 31, 2015	2015_325568_0038	032446-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Barnswallow Place Care Community
120 Barnswallow Drive Elmira ON N3B 2Y9

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

DOROTHY GINTHER (568), MARIAN MACDONALD (137), NUZHAT UDDIN (532), RAE MARTIN (515), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 15, 16, 17, 18 and 21, 2015

Three critical incidents log #023842-15, 030345-15, and 030405-15 were completed in conjunction with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Environmental Services Manager, Director of Programs, RAI Coordinator, Scheduling Coordinator, Falls Lead, one Registered Nurse, six Registered Practical Nurses, one nursing student, five Personal Support Workers, three Dietary Aides, a Maintenance Assistant, the Residents' Council representative, Residents and Families.

The inspectors also toured the resident care areas, medication room and storage area; observed dining service, medication administration, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control procedures; reviewed health care records and plans of care for identified residents, relevant policies, procedures and investigation notes, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
2 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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations during the initial tour of the home and throughout the Resident Quality Inspection (RQI) identified 17 out of 35 resident rooms (49 per cent) where the room and bathroom door frames were paint chipped and the lower portion of the wooden doors to the rooms and the bathrooms were gouged and scraped. It was also noted that the legs of the wooden chairs in the dining rooms and lounges were worn and scraped.

During a tour of the home with staff #121 and #122 they acknowledged and confirmed the identified areas of disrepair.

The licensee failed to ensure that the home and furnishings were maintained in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment were maintained in a safe condition and in a good state of repair, 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 staff received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

"Staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency and or other third party.

Critical incident investigation notes revealed that staff #124 witnessed an incident where staff #125 slapped a resident's hand.

An interview with staff #124 confirmed that they observed staff #125 slap a resident's hand. Interviews with the Executive Director #100 and Director of Care #101 confirmed that there was no documented evidence that staff #125 received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

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 staff received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During the initial tour of the home, a nursing station gate on one of the home areas was observed open and a binder containing a resident's clinical progress notes was visible on the desk. Staff #102 verified that personal health information (PHI) was not kept confidential and the gate should have been kept closed.

During a dining observatin a medication cart was noted to be unattended in the hallway outside of the dining room on one of the resident home areas. The electronic medication administration record (EMAR) screen was open and a resident's PHI was visible. Staff #105 acknowledged that the PHI was not kept confidential.

During an interview with the Director of Care #101, they confirmed that the home's expectation was that every resident had the right to have their personal health information kept confidential. [s. 3. (1) 11. iv.]

WN #4: 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 the organized program of nutrition care and dietary services included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

During the census review in stage 1 of the Resident Quality Inspection it was noted that 10 out of 40 residents (25 per cent) did not have an annual height for 2015.

During an interview with the Director of Care #101 they confirmed that there was a system in place to monitor and record heights annually, however it was not implemented for the 10 identified residents.

The licensee failed to ensure that annual heights were recorded for all residents in the home. [s. 68. (2) (e) (ii)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and kept inaccessible to residents at all times.

During the initial tour of the home, a cupboard door in an Activity Room on one of the home areas was found unlocked and hazardous substances including Easy Off Heavy Duty oven cleaner, All Purpose cleaner, Scotchguard fabric protector, and Ajax bleach cleanser were observed on a shelf in the cupboard. A sign posted on the cupboard door stated "this cupboard must be locked at all times".

The Executive Director #100 verified the observation and confirmed the home's expectation was that all hazardous substances were to be kept inaccessible to residents at all times. [s. 91.]

Issued on this 4th day of January, 2016

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

Original report signed by the inspector.