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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 14, 2017 | 2017_508137_0021 | 021970-17 | 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

MARIAN MACDONALD (137), SHARON PERRY (155)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): September 26-29 and October 2-3, 2017**

**The following intakes were completed within the RQI:**

**Falls Prevention**
**Log # 032277-16 / CIS 2830-000013-16**
**Log # 007067-17 / CIS 2830-000006-17**
**Log # 013575-17 / CIS 2830-000011-17**
**Log # 034192-16 / CIS 2830-000018-16**
**Log # 002409-17 / CIS 2830-000002-17**
**Log # 032753-16 / CIS 2830-000014-16**

**Prevention of Abuse, Neglect and Retaliation**
**Log # 000569-17 / CIS 2830-000001-17**

**Complaints**
**Log # 016817-17 / Written related to provision of care**
**Log # 021950-17 / IL-52908-LO related to provision of care**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, two Assistant Directors of Care, Director of Environmental Services, Director of Resident Programs, Director of Food Services, Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse (RN), five Registered Practical Nurses (RPN), five Personal Support Workers (PSW), two Dietary Aides, Resident's Council representative, Family Council representative, family members and residents.**

**The inspectors also toured the home, observed care provision, resident - staff interactions, medication administration, medication storage areas, reviewed residents' clinical records, relevant meeting minutes, internal investigative notes, medication incident reports and relevant policies and procedures.**

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

**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**

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

- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident, related to fall prevention devices.

A written notification and a voluntary plan of correction were previously issued, related to this subsection of the legislation, during a Resident Quality Inspection (RQI) on January 5, 2015, under Log # 001703-14 and Inspection # 2015_271532_0001.

Observations showed that an identified resident had a fall prevention device in place. During an interview, a PSW said that the device was one of the fall prevention interventions in place for the resident.

During a review of the plan of care, there was no documented evidence that the identified fall prevention device was used and was not included in the plan of care.

The Director of Care (DOC) and Inspector # 137 visited the resident's room and observed the fall prevention device in place.
A review of the care plan, with the DOC and Registered Practical Nurse (RPN), showed that the fall prevention device was not included in the care plan, as a fall prevention intervention.

DOC said the fall prevention device should have been included in the plan of care and that the care plan did not give clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. Observations showed another identified resident had a fall prevention device in place.

During an interview, a PSW said the device was one of the fall prevention interventions in place for the resident.

During a review of the plan of care, there was no documented evidence that fall prevention device was used and was not included in the plan of care.

Director of Care (DOC) and Inspector # 137 visited the resident's room and observed the fall prevention device in place for the resident.
A review of the care plan, with the DOC and Registered Practical Nurse (RPN) showed that the fall prevention device was not included in the care plan, as a fall prevention intervention.

The DOC said the fall prevention device should have been included in the plan of care and that the care plan did not give clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

A review of the plan of care for a third identified resident showed there were to be fall prevention devices in place.

A review of the progress notes showed that the identified resident sustained a number of falls. The fall prevention devices had not been activated or functioning properly at the time of the falls.

During an interview, the Director of Care (DOC) said the Personal Support Workers (PSW) were responsible to ensure the fall prevention devices were functioning properly and that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

4. A review of the plan of care for a fourth resident showed there were to be fall prevention devices in place.

A review of the progress notes showed that the resident sustained a number of falls,

without injury. The fall prevention devices were not in place at the time of the falls.

During an interview, the Director of Care (DOC) said the Personal Support Workers (PSW) were responsible to ensure the fall prevention devices were in place and that the care set out in the plan of care was not provided to the identified resident as specified in the plan. [s. 6. (7)]

5. A review of the plan of care for a fifth resident showed that the resident had an identified desired bedtime routine.
A review of the progress notes showed that the resident sustained a fall with injury and required an external assessment.
The resident was not in bed, at the time of the fall, as indicated in the plan of care.

During an interview, the DOC said that the resident should have been in bed, at the time of the fall, and that the care set out in the plan of care was not provided to the resident as specified in the plan.

This area of non-compliance was determined to have a severity on minimal harm or potential for actual harm (level 2), the scope was a pattern (level 2) and there was a previous related area of non-compliance issued in the last three years (level 3). [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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

A family member expressed concern that nail care was not being consistently provided to an identified resident and requested it be done, during the bath.

Inspectors # 137 and # 155 observed that the resident had not received the nail care as requested.
Registered Practical Nurse and Executive Director (ED) also observed that nail care had not been provided.

A review of the bathing records, showed documentation that the resident had a bath on an identified day and that nail care had been provided.
When interviewed by the Assistant Director of Care (ADOC), the Personal Support Worker (PSW) said that nail care had not been provided although they documented that nail care had been provided.

Inspector # 137 reviewed the "Follow up Question Report" in Point Click Care related to "Fingernails cut" for the month of September 2017.
The record showed there was documented evidence that 45/92 (49 percent) residents had a "No" response and did not have their fingernails cut during any bath or shower, in September 2017.

During an interview, the Director of Care (DOC) said they reviewed the "Follow up Question Report" in Point Click Care, for a specific time period and said that there were several residents who did receive nail care, according to the report and that they needed to tighten up their processes to ensure residents are receiving nail care.

The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

This area of non-compliance was determined to have a severity on minimal harm or potential for actual harm (level 2), the scope was a pattern (level 2) and there was no previous related area of non-compliance issued in the last three years (level 2). [s. 35. (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 all residents receive fingernail care, including the cutting of fingernails, to be implemented voluntarily.***

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**WN #3: 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 were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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 their health status.

A record review for an identified resident showed they had more than a 5 per cent weight loss in one month, more than a 7.5 per cent weight loss in three months and more than a 10 per cent weight loss in six months but the weight loss did not trigger an alert in Point Click Care (PCC).

During an interview, the Food Service Supervisor shared that they did not know why the

resident weights did not trigger an alert in Point Click Care for the weight loss in one, three and six months. They shared that the Registered Dietitian sees all residents in the home for any weight changes that are triggered in Point Click Care.

During an interview, the Director of Care shared that the Registered Dietitian was to assess all residents when there was a 5% weight change in one month, a 7.5% weight change in three months and/or a 10% weight change in six months. The DOC shared that the home relied on Point Click Care to generate these weight variance triggers and did not know why the identified resident's weight loss did not generate a weight loss trigger in the system.

The licensee failed to ensure that residents with the following weight changes were assessed, using an interdisciplinary approach, and that actions were taken and outcomes were 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 their health status.

This area of non-compliance was determined to have a severity on minimal harm or potential for actual harm (level 2), the scope was a isolated (level 1) and there was no previous related area of non-compliance issued in the last three years (level 2). [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

***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 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 their health status, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance.

Review of an identified resident's progress notes showed that the RPN recorded that they could not find a previous controlled substance. The RPN and RN both checked the resident and could not find the controlled substance.
RPN implemented checks every shift to ensure the controlled substance was in place.

During an interview, the Director of Care shared that they would have submitted a Critical Incident System (CIS) report if the controlled substance was not found and indicated that they feel it was found, as there was no CIS submitted. The Director of Care could not provide documentation indicating the date and location of where the controlled substance was found.

2. Another medication incident, for the same resident, showed that a controlled substance could not be located. Two RPN's checked the resident and were unable to locate the controlled substance.

During an interview, the Director of Care shared that they would have submitted a CIS report if the controlled substance was not found and indicated that they feel it was found as there was no CIS submitted. The Director of Care could not provide documentation indicating the date and location of where the controlled substance was found.

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident.

This area of non-compliance was determined to have a severity on minimal harm or potential for actual harm (level 2), the scope was a isolated (level 1) and there was no previous related area of non-compliance issued in the last three years (level 2). [s. 107. (3) 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 the Director is informed of missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.***

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**Issued on this 15th day of November, 2017**

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

**Original report signed by the inspector.**