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 prévue 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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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
Jan 31, 2019	2019_792659_0002	022215-17, 026638-17, 000351-18, 020146-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 22, 23 and 24, 2019.

The following intakes were completed:
Log #022215-17\Critical incident 2830-000018-17 related to resident fall with injury
Log #026638-17\Critical incident 2830-000019-17 related to resident fall with injury
Log #000351-18\Critical incident 2830-000001-18 related to resident fall with injury
Log #020146-18\Critical incident 2830-000008-18 related to alleged abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN)/ Falls lead, Personal Support Workers, Housekeeping staff.

Observations were completed for provision of care and staff to resident interactions. A review of clinical records, relevant policies and procedures and program evaluation were completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Two Critical Incidents (CI) were reported to the Ministry of Health and Long Term Care related to an identified resident who sustained falls with injuries and was transferred to hospital for assessment.

The clinical records for the identified resident showed the resident to be at risk for falls. Interventions were in place for falls management.

On a specified date, the resident sustained two unwitnessed falls within three days.

The home's policy for falls prevention stated that as part of the post fall assessment, "The Registered staff will: Monitor HIR as per the schedule on the form post fall for signs of neurological changes".

The schedule for the assessment of the head injury was identified on the HIR form and stated the resident was to be assessed immediately at the time of injury and at specified timeframes.

The HIR assessment form for a specified date showed there were four times when the HIR assessment was not completed.

The Falls lead and Director of Care (DOC) acknowledged the HIR was not completed and stated that this would have been a busy time of day for the registered staff. They acknowledged the expectation was that the staff follow the schedule for completion of the HIR.

The licensee had failed to ensure that the falls prevention policy was complied with related to completion of the head injury routine. [s. 8. (1) (a),s. 8. (1) (b)]

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 falls prevention policy is complied with; specifically to ensure that staff follow the schedule for completion of head injury routine assessments as indicated in the policy,, to be implemented voluntarily.

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.