Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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 20, 2020	2020_800532_0001	020903-19, 023674-19	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

NUZHAT UDDIN (532)

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 9-14, 2020.

**The following intakes were completed in this Critical Incident (CI) inspection:
Log #020903-19, CI #2830-000025-19 and Log #023674-19, CI #2830-000029-19 related to falls prevention.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (aDOC), Receptionist, Minimum Data Set (MDS)-Resident Assessment Instrument (RAI) Coordinator, Fall Lead Registered Nurse, (RN), Rehab Lead RN, Registered Nurses (RN) Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspector also toured resident home areas, observed resident care provision and resident staff interaction, reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(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. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure an identified resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

A critical incident (CI) was submitted to MLTC. The CI stated that an identified resident was found on the floor on an identified date.

A review of plan of care for the resident indicated that the biggest risk of falling for the resident was that they forgot to use their assistive device and under falls prevention the plan of care stated that the resident was to use an assistive device when in bed.

An RPN said that the resident rested in their chair but did not have an assistive device for their chair.

Another RPN reported the resident was sleeping in their chair just prior to the fall occuring, and there was no device related to falls prevention in place.

The Falls Lead RN stated that they were unaware that the resident was sleeping in their chair as there was no communication or documentation from staff and no request for an assistive device.

Resident Assessment Instrument (RAI) Coordinator acknowledged that the resident did sleep in their chair and went back and forth from bed to chair.

The licensee has failed to ensure that the identified resident was reassessed and the plan of care reviewed and revised when resident started sleeping in their chair and their care needs changed. [s. 6. (10) (b)]

2. The licensee has failed to ensure that when the identified resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, that the licensee considered different approaches to care in the revision of the plan of care.

A CI was submitted to the MLTC related to an identified resident’s fall resulting in injury.

A post fall assessment indicated that the resident was found on the floor and the assistive device was not activated.

Post fall assessments identified that a specified number of falls had occurred when the assistive device either did not activate or was turned off.

In the plan of care under falls prevention, it stated that the resident used an assistive device in bed, chair and wheelchair. The plan of care for the resident indicated that staff members were to be aware that the resident may turn off the assistive device.

On a specified date it was noted that the resident was sitting in their wheelchair and the assistive device was turned off.

The Falls lead indicated that they had monthly resident safety meetings where they reviewed resident's falls. They acknowledged that the assistive device was not always effective. The resident continued to have falls despite the assistive device and different approaches were not considered.

The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, that the licensee considered different approaches to care in the revision of the plan of care. [s. 6. (11) (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 ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; when a resident is reassessed and the plan of care reviewed and 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, to be implemented voluntarily.

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.