

**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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 17, 2022	2022_922119_0004	017830-21	Follow up

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

JANIS SHKILNYK (706119)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 7-9, 2022.

The following intake were completed within the follow up inspection:

Log #017830-21, which was a follow up to compliance order #001 from inspection #2021_922119_0002. This intake was related to ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Registered Practical Nurse (RPN), RPN-Rehabilitation Coordinator, RPN-Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSW), Housekeeping, resident.

During this inspection, the inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, relevant policies, and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

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

2 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2021_922119_0002		706119

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection control program. Staff did not perform or encourage hand hygiene for residents before or after eating.

The home's hand hygiene policy, IX-G-10.10, last updated December, 2021, stated staff were to wash resident's hands before and after eating, after toileting, when hands were soiled, after touching therapy equipment, visiting animals, and after activities involving touching and eating. The preferred method if hands were are not visibly soiled was with ABHR (alcohol based hand rub).

During a meal staff were observed on eight occasions providing residents food and/or fluids and did not perform, offer or encourage hand hygiene to the residents.

Staff were observed on two occasions providing residents with food/fluids from the nourishment cart and did not perform, offer or encourage hand hygiene to the residents.

A resident stated they were not assisted with hand hygiene prior to their meal and should have been.

Staff were observed assisting a resident after their meal to their room and did not perform, offer or encourage hand hygiene to the resident. Another resident exited the dining room on their own and was not offered or encouraged to complete hand hygiene. Staff were present in the dining room.

Staff, including management indicated that it was the home's expectation that resident hand hygiene was to be preformed using hand sanitizer prior to a meal or nourishment.

The potential risk of harm to residents may occur from the potential spread of infection related to not washing or hand sanitizing residents' hands before or after meals and nourishment.

Sources: resident observations, DOC, RPN, PSW's, and resident interviews. Hand Hygiene Policy, # IX-G-10.10, last revised December 2021. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101.
Conditions of licence**

Specifically failed to comply with the following:

Conditions of licence

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee failed to comply with parts D and E of Compliance Order (CO) #001, related to developing and implementing an audit to ensure that all residents using a lift were in the correct sling size/style, and the information was to be included in the resident's plan of care. In addition, they were to develop and implement an audit to ensure that staff were observed performing safe lift and transferring techniques for residents.

Staff confirmed that audits were not completed for residents using a lift, including the correct sling size/style, and updating of the resident's plan of care. Staff confirmed that auditing to ensure that staff were performing safe lift and transferring techniques for residents was also not done.

The risk of harm to residents may occur when auditing is not completed as required, because processes related to correct sling/size and safe transferring techniques may not be captured. [s. 101. (3)]

Issued on this 18th day of February, 2022

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : JANIS SHKILNYK (706119)

Inspection No. /

No de l'inspection : 2022_922119_0004

Log No. /

No de registre : 017830-21

Type of Inspection /

Genre d'inspection: Follow up

Report Date(s) /

Date(s) du Rapport : Feb 17, 2022

Licensee /

Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414
Investment LP
302 Town Centre Blvd., Suite 300, Markham, ON,
L3R-0E8

LTC Home /

Foyer de SLD : Barnswallow Place Care Community
120 Barnswallow Drive, Elmira, ON, N3B-2Y9

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** Catherine Schalk

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # /

No d'ordre : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must comply with r. 229 (4) of O. Reg. 79/10.

- a) Ensure staff comply with the home's hand hygiene policy.
- b) Re-educate direct care staff on the home's Hand Hygiene Policy # X-G-10.10, specifically to ensure they offer and assist residents with hand hygiene before and after eating. A record of the education, including the date and the staff member who provided the education should be kept at the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection control program. Staff did not perform hand hygiene for residents before or after eating.

The home's hand hygiene policy, IX-G-10.10, last updated December, 2021, stated to wash resident's hands before and after eating, after toileting, when hands are soiled, after touching therapy equipment, visiting animals, and after activities involving touching and eating. The preferred method if hands were not visibly soiled was with ABHR (alcohol based hand rub).

At a meal staff were observed on eight occasions providing residents food and/or fluids for tray service and did not perform or offer hand hygiene to the residents.

Staff were observed on two occasions providing residents with food/fluids from the nourishment cart and did not perform or offer hand hygiene to the residents.

A resident stated that they had not been assisted with hand hygiene prior to their

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

meal and should have been.

Staff were observed assisting a resident after their meal to their room and did not perform or offer hand hygiene to the resident. Another resident exited the dining room on his own and was not offered or encouraged to complete hand hygiene. Staff were present in the dining room at the time.

Staff, including management indicated that it was the home's expectation that resident hand hygiene was to be performed using hand sanitizer prior to a meal or nourishment.

The risk of harm to residents may occur from the potential spread of infection related to not washing or hand sanitizing residents' hands before or after meals and nourishment.

Sources: resident observations, DOC, RPN, PSW's, and resident interviews. Hand Hygiene Policy, #IX-G-10.10, last revised December 2021.

An order was made by taking the following factors into account:

Severity: The potential risk of harm to residents may occur from the potential spread of infection related to not washing or hand sanitizing residents' hands before or after eating.

Scope: The scope of this non-compliance was a pattern as multiple residents did not perform hand hygiene before and after eating.

Compliance History: One written notification (WN) and one voluntary plan of correction (VPC) to the same subsection and eight WN's, five VPC's and one compliance order (CO) were issued to the home related to different sections of the legislation in the past 36 months.

(706119)

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Mar 25, 2022

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
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2007, c. 8

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foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of February, 2022

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Janis Shkilnyk

Service Area Office /

Bureau régional de services : Central West Service Area Office