Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 21, 2023

Inspection Number: 2023-1315-0005

Inspection Type:
Complaint
Critical Incident System

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Barnswallow Place Care Community, Elmira

Lead Inspector	**Inspector Digital Signature**
Robert Spizzirri (705751)	Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2023.02.21 15:34:28 -05'00'

Additional Inspector(s)
Diane Schilling (000736) was present at this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 6-9, 14-16, 2023
The following intake(s) were inspected:

- Intake: #00019042 was related to fall prevention and management.
- Intake: #00015769 was related to fall prevention and management.
- Intake: #00019036 was related to alleged abuse, skin and wound, and resident care and support services.
- The following intakes were completed in this inspection: Intake: #00015817 and #00017806 were related to fall prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) is implemented.

The IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 stated the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum Routine Practices shall include the proper use of personal protective equipment (PPE), including appropriate selection and application.

Rationale and Summary
A resident was isolated under droplet and contact precautions which required the use of eye protection. Signage was posted upon entering their room which said eye protection was required within 2 metres of the resident.

Two staff were observed to enter the room on three separate occasions. They were within 2 metres of the resident and did not wear eye protection.

The IPAC Lead said that staff were expected to wear eye protection due to the residents symptoms.

When staff do not wear the required PPE, it increases the risk of transmission of infection.

Sources: Observations, Droplet/Contact Signage, Interview with IPAC Lead and other staff.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that there were written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours of a resident.

Rationale and Summary
A resident was identified to have responsive behaviours.

A PSW said they are to reapproach the resident when they decline care; however, if the resident resists, staff would hold the residents' arms down while providing care.

The Behavioural Supports Ontario (BSO) Lead said that staff should not hold anyone down while providing care. They said staff have access to the care plan or BSO binder to review interventions when responding to responsive behaviours. Upon review, there were no written strategies, techniques or interventions documented to assist staff in responding to the resident's responsive behaviours.

When there are no written strategies, techniques, or interventions on how to respond behaviours, staff may perform actions that are unsafe and put the resident at increased risk of harm.

Sources: Resident's care plan, BSO Binder, interviews with BSO Lead, and other staff.

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