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: July 24, 2023

Inspection Number: 2023-1315-0006

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**
Gurvarinder Brar (000687)	Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.07.24 12:57:23 -04'00'

Additional Inspector(s)
Josee Snelgrove (674)
April Racpan (218)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-14 and 17-19, 2023.

The following intake(s) were inspected:

- Intake: #00021947 related to falls prevention and management.
- Intake: #00089022 related to prevention of abuse and neglect.
- Intake: #00086959 related to prevention of abuse and neglect.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect by staff.

The Ontario Regulation 246/22 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

The home’s Resident Safety Rounds Policy stated that all residents were required to be checked upon staff’s arrival to the home area at the beginning of their shift and prior to leaving their shift. Additionally, all residents were required to be checked for a minimum of every two hours.

A resident was found on the floor by staff after they fell and sustained injuries. The resident was not checked for an extended period of time before they were identified.

The Director of Care (DOC) acknowledged that the home’s policy related to completing safety checks was not followed when staff failed to check on the resident for an extended period of time. This delayed the staff’s response time in assessing and taking clinical actions.

Failure to provide the resident with the services required for their health and safety by not complying with the home’s policy for completing safety checks, placed them at moderate risk of harm for worsening injuries.

Sources: Critical Incident (CI) Report, Resident Safety Rounds Policy, VII-H-10.20, last revised April 2019, resident clinical records, Point Click Care (PCC) risk assessment reports, interviews with Director of Care (DOC) and other staff.

[674]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that when there was reasonable grounds to suspect that abuse had occurred, that they immediately reported the suspicion and the information upon which it was based to the Director.

Rational and Summary

A staff member suspected that a resident was a recipient of abuse with injuries. The incident was not reported to the Director until one day later.

Not immediately reporting the incident of suspected abuse to the Director, could have delayed actions in response to the incident which placed the resident at risk of harm.

Sources: CI Report and Interview with the Executive Director.

[000687]