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: December 13, 2023

Inspection Number: 2023-1315-0007

Inspection Type:
Complaint
Critical Incident

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

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

Lead Inspector	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2023.12.15 08:55:57 -05'00'

Additional Inspector(s)
Nuzhat Uddin (532)
Mark Molina (000684)

Kelly Daley, Triage Inspector, was present during the inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30-31 and November 1-3, 6-10, 15-16, 2023

The following intake(s) were inspected:

- Intake: #00094042 - related to falls prevention and management
- Intake: #00097965 - related to an outbreak
- Intake: #00098154 - related to improper transfer
- Intake: #00099423 - related to an unexpected death
- Intake: #00099542 - complaint related to plan of care

The following intakes were completed in this inspection:

- Intake #00094507, #00096207, and #00098992 were related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Emergency Plans

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

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,

vi. medical emergencies,

The licensee has failed to ensure staff responded to the home's Medical Emergency policy during a medical emergency with a resident, as required.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or

Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Medical Emergency policy stated that in the event of a life threatening medical emergency affecting any individual, a code would be called to alert team members and prompt an appropriate response in accordance with the Emergency Plan. A code was to be called to alert nearby staff. Following notifying the staff, the Power of Attorney (POA) was to be notified and CPR was to be continued until arrival of 911.

Rationale and Summary
A resident had a medical emergency and a staff member initiated CPR. The Medical Emergency policy was not followed when this incident occurred.

By failing to follow the home's Medical Emergency policy, staff did not respond to the medical emergency as required.

Sources: interviews with staff and record review of the home's Medical Emergency policy, the ambulance call report and Critical Incident report
[705769]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was accurately documented.

Rationale and Summary
A resident's plan of care included specific emergency interventions. At the time of an incident, a form was completed indicating the specified interventions were not to be performed.

As a result of the inaccurate documentation, the interventions were not performed for a period of time.

Sources: interviews with staff, record review of the form completed, the ambulance call report, and a resident's clinical records.
[705769]

WRITTEN NOTIFICATION: Staff Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 1.
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.

The licensee has failed to ensure that a record was kept for each staff member of the home that included the staff member's qualifications.

Rationale and Summary
The job descriptions for registered staff within the home indicated that they must have a specific certification to work as a Registered Nurse (RN) or Registered Practical Nurse (RPN) at the long-term care home. When the inspector requested to see a copy of the specific certification status for each of the registered staff within the home, the home sent out an email to all registered staff requesting them to send a copy to the home by the end of the day. Out of 29 certificates, five of them were expired.

By failing to keep a record of the qualifications for each staff member, they were unaware of the certification status for the registered staff. This posed a risk of the staff not being qualified to provide the required care in an emergency situation.

Sources: interview with staff, record review of the registered staff job descriptions, email sent to registered staff, and certificates for registered staff.
[705769]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that resident's rights to have their personal health information within the meaning of the Personal Health Information Protection (PHIP) Act, 2004 was kept confidential in accordance with the Act.

Rationale and Summary
A staff member discussed care that was provided to a resident through text messages.

By communicating personal health information through text messages, there was a breach of confidentiality.

Sources: interviews with staff, record review of the home's pledge of confidentiality, the text messages sent by the staff, and the PHIP Act, 2004.
[705769]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques while transferring a resident.

Rationale and Summary
A resident was injured while being transferred with a mechanical lift when the two staff did not communicate to one another prior to raising the resident in the lift.

By not communicating with one another, the resident was not being watched the whole time and resulted in injury.

Sources: interviews with staff.
[705769]

WRITTEN NOTIFICATION: Complaints - reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The long-term care home failed to forward a written complaint that involved concerns about a resident's care to the Director.

As per O. Reg. 246/22, s. 109 (1) a complaint that a licensee is required to immediately forward to the Director is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

Rationale and Summary
Staff received an email outlining care concerns about whether a resident received the appropriate care at the time of an emergency. The complaint was not forwarded to the Director.

By failing to report the complaint to the Director, there was risk of the concern not being looked into as required and the Director not being able to make appropriate decisions.

Sources: interviews with staff, and record review of the email sent from the complainant.
[705769]