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
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Original Public Report

Report Issue Date: August 20, 2024

Inspection Number: 2024-1315-0003

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25-28, 2024, and July 2-5, 8-10, 2024.

The following intake(s) were inspected:
• Intake: #00114451, a complaint related to medication management, pain management, residents rights and choices, prevention of abuse and neglect, and, reporting and complaints.
• Intake: #00116079, a complaint related to medication management, and skin and wound prevention and management.
• Intake: #00114879, related to falls prevention and management.

The following intake was completed in this inspection:
• Intake: #00116162, related to falls prevention and management.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff involved in a resident's care collaborated with each other in the development and implementation of the plan of care for falls prevention so that different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary

Upon the resident's admission to the home, the resident was at risk for falls. The

resident had a fall. It was unknown when some fall prevention interventions were initiated and when they were no longer provided as there was no communication with the home's physiotherapist or the Falls Lead.

The Physiotherapist recommended several fall prevention interventions to minimize injuries from falls however these interventions were not implemented.

A post fall assessment was completed for the resident after another fall. A specific piece of fall prevention intervention equipment was near the resident. The Physiotherapist did not know when the equipment was implemented for the resident and the Occupational Therapist had not been sent a referral to complete an assessment for this equipment.

The resident had another fall. The Physiotherapist was unable to assess the resident post fall as the referral was incorrectly completed and they were not notified about the fall. The resident then had another fall and sustained an injury.

The DOC acknowledged gaps in the communication amongst the multidisciplinary team members involved in resident's care. They said the appropriate referrals were not completed as required.

Staff not collaborating in the development and implementation of the resident's plan of care related to falls prevention and management resulted in interventions not being properly implemented, assessments being missed and referrals not being made. This may have contributed to the resident continuing to fall and sustain injuries.

Sources:
Critical incident report, the residents care plan, progress notes, physiotherapy

assessments, fall risk assessment and interviews with staff, the home's Falls Lead, the home's physiotherapist, and the DOC.
[758]

WRITTEN NOTIFICATION: Reports of investigation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of an investigation and actions taken in response to a verbal complaint alleging abuse of a resident were reported to the Director.

Rationale and Summary

A verbal complaint alleging abuse of a resident was reported to the home.

The home completed an investigation of the alleged abuse, but the results of the investigation and the actions taken were not reported to the Director.
Failing to immediately report to the Director the results of the investigation and actions taken in response to allegations of abuse of a resident, limited the Director's ability to respond to the incident in a timely manner, if required.

Sources:
The home's complaint records, the residents progress notes, the home's policy#XXIII-E-10.00, Complaints Management, last revised in December 2023, and an interview with the DOC.
[758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that the residents falls prevention and management interventions and their responses to the interventions were documented.

Rationale and Summary

A resident sustained numerous falls, one resulting in an injury.

i) The resident had a fall, and it was documented that there were specific falls interventions in place at the time of the fall. There was no documentation in the resident's plan of care to show when these interventions were initiated, and discontinued and what was the resident's response to the interventions

The resident had another fall. The post fall assessment documented the resident had specific falls intervention in place, however the resident's plan of care did not include this intervention.

The resident had a third fall where an intervention and equipment related to falls prevention and management were identified as being present during the post fall assessment. Again, there was no indication of when the interventions started and whether the resident was assessed for the interventions.

The DOC and the home's Falls Lead said that the interventions provided to the resident and the effectiveness of these interventions should be documented in the resident's plan of care.

ii) The resident's post fall assessments completed on several dates did not document the outcomes of the post fall interdisciplinary discussion as required according to the DOC.

iii) The resident was placed on a specific falls prevention intervention. There were multiple occasions when the intervention was not documented as completed.

By not documenting the falls prevention interventions provided to the resident and the resident's responses, it made it difficult to evaluate the effectiveness of these interventions.

Sources:
The residents progress notes, care plan, post fall assessments, 30-minute safety checks, and interviews with the home's Falls Lead, and the DOC.
[758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response to the person who made complaints related to a resident's care included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

The home received five verbal complaints concerning the care of a resident.

The response provided to the complainant did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman.

By not providing the required information to the complainant, it, limited their ability report their concerns to other parties if desired.

Sources:
The resident's progress notes, complaint records, and interviews with the Resident and Family Experience Coordinator, and the DOC.
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WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee failed to ensure that the record of a complaint that alleged abuse of a resident included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary

A verbal complaint alleging abuse of a resident was received by home.

The DOC acknowledged that the complaint record did not include the date on which any response was provided to the complainant and a description of the response.

By not documenting the above information on the complainant record, there was a risk that this information may not be taken into consideration when reviewing and analyzing the complaint to determine what improvements were required in the

home.

Sources:
The home's complaint records and an interview with the DOC.
[758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(f) any response made in turn by the complainant.

The licensee failed to ensure that the record of two complaints related to a residents care and one complaint alleging abuse of another resident, included the response made in turn by the complainant.

Rationale and Summary

Two verbal complaints related to the resident and one verbal complaint alleging abuse of the other resident was received by the home.

The DOC and the Resident and Family Experience Coordinator acknowledged that these complaint records did not include the response made by the complainant, as required.

By not documenting the complainant's response, there was a risk that their feedback may not be taken into consideration when reviewing and analyzing the

complaint records.

Sources:
The home's complaint records and interviews with the DOC and the Resident and Family Experience Coordinator.
[758]

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Non-compliance with O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to two residents in accordance with the directions for use specified by the prescriber.

A) Rationale and Summary

A resident had a new medication order. The directions for use were to give four times a day.

The resident received half of the dosage on six occasions.

By not following the prescriber's directions for the administration of a new medication, it could impact the resident's health.

Sources
The residents clinical records, The residents physicians orders, progress notes, interviews with staff.
[000690]

B) Rationale and Summary

The resident had a medication order. Progress notes stated that on two dates the resident was found with the medication applied incorrectly.

By not following the prescriber's directions for the administration of the medication, they may have put the resident at risk for adverse effects.

Sources
The residents clinical records, the residents progress notes, Medication Incidents, Interview with Director of Care.
[000690]

C) Rationale and Summary

A new order was prescribed for the resident to manage their medical condition.

The medication was administered daily, however there was no indication that the resident was assessed prior to the administration of the medication.

A staff member said they were not aware of the directions for the administration of the medication and did not assess the resident prior to the administration of the medication.

The ADOC said the order for the medication was processed incorrectly. The directions for use for the medication were not updated to include the assessment of the resident until after the Long-Term Care Home Inspector's discussion with the home.

Sources:
The residents physician's orders, electronic medication administration records (eMAR), progress notes, weights and vitals records, and interviews with staff.
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WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (3), or
(B) is an internationally trained nurse who is working as a personal support worker.

O. Reg. 66/23, s. 28 (1). Or

Non-compliance with O. Reg. 246/22, s. 140 (3) (b) (ii).

The licensee has failed to ensure that a personal support worker (PSW) received training on the administration of drugs in accordance with the home's medication assistance policy.

Rationale and Summary

The home's Medication Assistance Policy stated that PSWs can administer drugs under prescribed condition, including that any PSW who administers the drug to a resident receives training on the administration of drugs and is assigned and supervised to perform the drug administration by a member of the community's registered nursing team.

The resident had a medication order that had specific direction of when to apply and remove the specific medication.

A PSW was participating in the removal of the medication and would report it back to a staff member in order for them to complete the documentation on the electronic medication administration record (eMAR).

The PSW's training and education records showed that they did not complete the required medication administration training.

The home's failure to ensure that the PSW had received training in the administration of drugs in accordance with written policies and protocols increased the risks associated with incorrect medication use.

Sources
The residents clinical records, Medication Assistance Program, VIII-E-20.00 dated April 2024, Interviews with staff.
[000690]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and was reported to the physician, the DOC and the pharmacy provider.

Rationale and Summary

A resident reported to a staff member that one tablet of their medications was on the side table in their room.

The staff member found the tablet on the floor by the resident's bed and later identified that it was a specific medication which the resident was to receive regularly.

There was no documentation of this incident until after the Inspector's discussion with the home. Additionally, there was no documentation of any immediate actions taken to assess the resident and no notification of the resident's physician, the DOC and the pharmacy provider.

Staff said that a medication incident should have been submitted in relation to the omission of a residents medication dose and the physician, the DOC and the pharmacy notified.

By not documenting and reporting a medication incident related to the omission of the residents medication, the incident could not be reviewed and analyzed and corrective actions to prevent recurrence could not be implemented in a timely manner.

Sources:
The residents progress notes, eMAR, physician's orders, CareRx policy # #9.2 Medication Incident Reporting, last revised on June 30, 2023, and interviews with staff.
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