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: November 6, 2024

Inspection Number: 2024-1315-0004

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): October 16 -18, 22 - 25, 28, 2024

The following intake(s) were inspected in this compliant inspection:

- Intake #00128259 – Prevention of Abuse and Neglect, Housekeeping, Laundry and Maintenance Services
- Intake #00125904 – Prevention of Abuse and Neglect, Housekeeping, Laundry and Maintenance Services, Food, Nutrition and Hydration

The following intakes were inspected in this Critical Incident inspection:

- Intake #00119535 – Falls Prevention
- Intake #00123509 - Infection Prevention and Control
- Intake #00123387 – Resident Care and Support Services
- Intake #00125158 – Prevention of Abuse and Neglect
- Intake #00122087 – Skin and Wound Prevention

The following intake was completed in this inspection:

- 00121684 - Infection Prevention and Control

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

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The Licensee has failed to ensure that a bathtub was cleaned and disinfected after each use.

Rationale and Summary:

The tub used for resident baths was not cleaned after resident use. the IPAC Lead identified this in an audit and provided training to the staff. Subsequently, the tub was cleaned.

Prior to the end of the inspection the tub was observed to be clean and free of hair and debris.

Sources: Observations, and interview with PSWs #104 and #109 and IPAC Lead.

Date Remedy Implemented: October 24, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital

status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality, while Care Support Assistant (CSA) #129 assisted them with their meal.

Rationale and Summary
CSA #129 was assisting a resident with their meal from a standing position In a manner that did not fully respect their dignity.

By failing to respect the resident's rights and treating them with courtesy and respect while assisting them with their lunch, the resident is at risk of having negative feelings towards meal time or could result in emotional impact.

Sources: observation of meal and interviews with CSA #129 and the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

A resident's attending physician wrote a letter indicating that the resident was fully dependent on others for care.

Up until a week after the physician wrote the letter, the resident's plan of care indicated that they were able to provide oral care on their own.

By failing to ensure that the resident's plan of care provided clear direction to staff, there was risk of staff not providing the resident with the required oral care.

Sources: interview with PSW #110 and the DOC and record review of a resident's clinical records.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rational and Summary:
A resident's plan of care indicated that raw fruit, vegetables, and salads should not be served. However, an observation showed that they were served a chef salad containing raw broccoli and cabbage.

PSWs #104 and #107 stated they were not aware of this restriction.

The resident was at risk of not meeting their nutrition goals when their plan of care was not followed.

Sources: Resident meal observation, review of clinical records, interview with PSW #104, #107 and staff #108.

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed when their care needs changed.

Rational and summary:
A concern was raised about a resident's inability to feed themselves independently.

A referral to the Rehabilitation Nurse was made, but the assessment was not completed. The Rehabilitation Nurse acknowledged that a complete assessment should have been conducted.

The resident was at risk of not meeting their nutritional requirements when an assessment was not completed after they were unable to feed themselves

independently.

Sources: Resident mealtime observation and medical record review, interview with RPN and other staff.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint that they received concerning the care of a resident.

Rational and summary:
The home received a written complaint related to multiple concerns regarding the care of a resident. A review of the home's internal investigation indicated that the complaint was not forwarded to the Director.

Staff #111 stated that the complaint was dealt with internally and was not reported to the Director. The Director of Care (DOC) stated that the complaint should have been reported to the Director.

Failure to report the written complaint regarding the resident's care may have delayed the Director's response.

Sources: Review of the home's internal investigation of the written complaint, interview with staff #111, Director of Care and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director when there was a report of an allegation of abuse to a resident.

Rationale and Summary:
A visitor to the home reported to Assistant Director of Care (ADOC) #118 that a resident told them that they have experienced abuse by staff in the home.

The home's internal investigation indicated that they did not notify the Director until three days later.

The Assistant Director of Care (ADOC) said that the allegation of abuse was supposed to be reported to the Director immediately.

Failure to immediately report the allegations of abuse and neglect may have delayed the Director's response.

Sources: Critical Incident Report, resident observation and medical record review, interview with ADOC #118 and other staff.

WRITTEN NOTIFICATION: Training

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee has failed to ensure that no person performs their responsibilities before receiving training in the areas that are relevant to the person's responsibilities.

Rational and summary:
A review of the training records for the home's Rehabilitation Nurse indicated that they did not receive specialized training relevant to their responsibilities prior to starting their role.

The Director of Care (DOC) stated that the Rehabilitation Nurse was supposed to receive an offsite specialized training for their role but had not.

The residents were put at risk of not receiving appropriate assessments when the Rehabilitation Nurse did not receive specialized training for their responsibilities prior to starting their role.

Sources: Review of Rehabilitation Nurse's training records, interview with Rehabilitation Nurse and DOC.

WRITTEN NOTIFICATION: Training

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (6) 2.
Training
s. 82 (6) Every licensee of a long-term care home shall ensure that the following are done:
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations.

The licensee has failed to ensure that the further training needs identified by the assessments for staff on a specific unit were addressed in accordance with the requirement provided for in the regulations.

Rational and Summary:
The home received a written concern, resulting in an internal investigation regarding multiple care-related issues involving a resident.

The investigation indicated the need for training of all staff on a specific unit. However, there was no documentation that this training had been conducted. Assistant Director of Cares (ADOCs) #116 and #118 stated that they had not provided

the training.

The same concerns were raised again, leading the home to identify areas where immediate training was required for all staff on the same unit. ADOC #118 completed training for five afternoon staff members only. They stated there was no sign-in sheet for the training, and they were uncertain if all staff received the required training as indicated by the investigation.

Failure to provide education to all staff on the areas identified during the internal investigation may have contributed to a resident's care concerns and led to communication issues with their POA, resulting in the submission of another complaint regarding the same concerns raised two months earlier.

Sources: Review of written complaints and internal investigation, staff training and communication with the POA, interview with ADOC #116, #118 and other staff.

WRITTEN NOTIFICATION: Oral Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee failed to ensure that a resident received oral care to maintain integrity of the oral tissues, including mouth care in the morning and evening.

Rationale and Summary
In a one week period there was no documentation indicating mouth care was

provided to a resident during both morning and evening care. On certain days, there was no documentation that the resident received oral care during morning care.

By failing to ensure that the resident received oral care in the morning and evening, there was risk of the resident's oral tissues being compromised.

Sources: interviews with staff and record review of a resident's clinical records and the home's written response to the complainant.

WRITTEN NOTIFICATION: Oral Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (c)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventative dental services from September 2022 to September 2024.

Rationale and Summary
In September 2022, the home offered dental services to all the residents. Following that, no other dental services were offered to all residents until September 2024. There was a contract signed for dental services in May 2023, but no information was sent out to families regarding these services.

By failing to ensure each resident was offered an annual dental assessment and other preventative dental services, there was risk of residents not receiving the proper oral care which could have potentially lead to oral health issues for residents.

Sources: interviews with the ED and DOC and email communication amongst Barnswallow management and the Dental Services.

WRITTEN NOTIFICATION: Transferring and Positioning

NC #012 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 failed to ensure staff used safe transferring techniques for a resident while using a lift device.

Rationale and Summary:

A resident was being transferred by two PSWs. During the transfer there was a malfunction of the lift and the resident fell to the floor.

Failure to ensure the staff used safe techniques while using the lift device resulted in a fall with injury to the resident.

Source: Critical Incident Report, resident progress notes and interviews with the resident, PSW #101 and Falls Lead.

WRITTEN NOTIFICATION: Dining and snack service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that during dining service, a resident was provided the recommended assistive device, to help them eat and drink as safely, comfortably, and independently as possible.

Rational and summary:
A resident's plan of care indicated that they drank better with a straw and required an assistive device for their fluids for ease of consumption.

The resident was observed without their assistive device.

A Personal Support Worker (PSW) stated that they were not aware of this requirement.

The resident was at risk of not meeting their nutrition and hydration needs when they were not offered their assistive device as per their plan of care.

Sources: Resident meal observation and review of medical records, interview with PSW #104 and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control - Audits and Signage

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

In accordance with the IPAC Standard, revised September 2023, section 7.3, (b), the IPAC Lead shall ensure that audits are performed regularly, at least quarterly, to ensure that all staff can perform their IPAC skills required of their role.

Specifically, the licensee has failed to ensure that the IPAC lead has implemented audits, at least quarterly, to confirm that all staff can perform the IPAC skills required of their role.

Rationale and Summary

Infection Prevention and Control (IPAC) Audits, provided by the IPAC lead, included Personal Protective Equipment (PPE) and hand hygiene audits.

The review of the audits shows there were no audits that provided a structured process to ensure that staff from different disciplines and shifts were audited and could perform the IPAC skills required of their role.

The IPAC Lead stated that staff sign-off annually on IPAC training and IPAC is reviewed at team meetings; however, the home does not have a formal audit that is

completed every three months to ensure staff are performing IPAC skills required for their role.

Failure to conduct IPAC skills audits placed the residents and staff at risk of infection transmission.

Sources: record review of IPAC audits and interview with the IPAC Lead.

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

In accordance with the IPAC Standard, revised September 2023, section 9.1, (e) point-of-care signage indicating that enhanced IPAC control measures are in place.

Specifically, the licensee has failed to ensure that signage was posted on the door of a resident who tested positive for COVID.

Rationale and Summary

A resident was confirmed COVID positive and there was no signage for additional precautions posted on their room door or inside the resident's room.

When the inspector inquired about the signage, RPN #106, Housekeeper #114 and the IPAC Lead stated that the resident removes the signs from the door. No alternative solutions were tried to ensure the signage remained on the room door.

Failure to ensure the additional precautions signage was posted on the resident's door placed residents and staff at risk of not being aware of the concerns with entering the room.

Sources: Observations and interview with Infection Control Lead.

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