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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Public Report

Report Issue Date: December 10, 2024

Inspection Number: 2024-1315-0005

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): December 2- 6, 2024

The following intake(s) were inspected:

- Intake: #00129232 - Alleged neglect of a resident during care.
- Intake: #00130221 - Improper care of a resident, alleged neglect.
- Intake: #00130741 - Improper care of a resident during care.
- Intake: #00130808 - Concerns related to improper care of a resident.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 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 has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions are documented.

Rational and summary
A review of a resident's care records revealed multiple instances of missing documentation.

The Assistant Director of Care (ADOC) stated that staff were expected to document care daily.

There was a risk of the resident not meeting their care needs when the care was not documented.

Sources: Observation and review of medical records of the resident, interview with ADOC and other staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 ensure that two staff members used safe positioning techniques while transferring a resident.

Rational and summary
Two staff members used improper positioning techniques while transferring a resident.

The resident was put at risk of injury when they were not safely positioned during a transfer.

Source: Critical incident report, observation and review of the resident's medical records, interview with ADOC and other staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident received assistance from staff to manage and maintain continence.

Rational and summary
The communication and response system was activated when a resident needed assistance with care but the response system was not responded to in a timely manner.

The resident's continence care needs were not met due to the delayed response.

Sources: Observation and medical record review of the resident , review of the home's internal investigation, interview with Director of Care and other staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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).

In accordance with the IPAC Standard, revised September 2023, section 7.3, (b), the IPAC Lead shall ensure that audits are performed as required.

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 included Personal Protective Equipment (PPE) and hand hygiene audits.

A review of the hand hygiene audits revealed multiple instances of non-compliance. However; there was no structured process to track non-compliant staff and their training.

Failure to conduct IPAC skills audits to ensure all staff can perform the IPAC skills required of their role, placed the residents and staff at risk of infection transmission.

Sources: Review of the home's IPAC audits, IPAC observations and interview with IPAC Lead.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs are stored in an area or a medication cart that was secure and locked,

Rational and summary
A Long Term Care Home (LTCH) Inspector observed the medication cart on a

home's neighborhood unattended and unlocked.

A Registered Nurse (RN) stated that they should have locked the medication cart when they were away from it.

This failure to adhere to the specified storage protocols posed a risk to the privacy and safety of residents.

Sources: Medication cart observation, interview with RN, ADOC.