Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2016	2016_393606_0006	007467-16	Resident Quality Inspection

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

Long-Term Care Home/Foyer de soins de longue durée

ROBERTA PLACE
503 ESSA ROAD BARRIE ON L4N 9E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANET GROUX (606), CECILIA FULTON (618), MATTHEW CHIU (565), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 18, 21, 22, 23, 24, 29, 30, 31, April 1, 4, and 5, 2016.

CSC critical incidents (CI)
#003481-14, 029389-15, 004849-14, 007540-14, 004436-15, 004889-15, 004922-15, 010465-15,
017541-15, 020184-15, 002256-16, 032464-15, 028776-15, 029997-15, 029208-15, 028786-15,
028068-15, 030522-15, 002955-15, 003689-16, 012798-15, complaints #002691-14/003380-14,
003101-16, and 004768-15, and order # 013642-15.

During the course of the inspection, the inspector(s) spoke with the Administrator (A), Director of Resident Care (DRC), Co-Director of Resident Care (C-DRC),Staff Educator (SE), Registered Dietitian (RD), Dietary Manager (DM), Dietary Aide (DA), Physiotherapy Assistant (PTA), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Volunteer Services Coordinator (VSC), Life Enrichment Coordinator (LEC), Resident and Family Services Coordinator (RFSC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Restorative Care Aide (RCA), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition and Hydration Program included the implementation of interventions to mitigate and manage identified risks.

A review of a previous Compliance Order issued during the 2015 Residents' Quality Inspection (RQI), revealed that the home's hydration program failed to include the identification of any risks related to hydration as there were no clear directions to registered staff on monitoring and evaluating fluid intake and when to identify when a resident has not been consuming enough fluids.

The order was issued to include the identification of any risks related to hydration and the implementation of interventions to mitigate and manage the risks. The following ground revealed that the licensee had failed to comply with the implementation of interventions to mitigate and manage the hydration risk.

- On three identified dates and time, the inspector observed water was not available in resident #003 and #005's room.

A review of resident #003's care plan directed staff to provide water in the resident's room, and to offer to the resident each time staff entered the room.

Interview with PSW #113 revealed that he/she was not aware about the above mentioned fluid intervention for the resident.

Interview with RN #100 confirmed that there was no water in the resident's room and staff were required to be aware of and provide care set out in the plan of care.

Interview with the DM and RD confirmed that staff should be aware of the plan care of care and are required to implement interventions developed in the plan of care.

A review of resident #005's care plan revealed the resident is at risk for dehydration related to altered skin integrity, medication and medical diagnosis. An intervention to increase fluid intake directed staff to provide water in the resident's room and to offer to the resident each time staff entered the resident's room.

Interview with PSW #114 revealed that he/she was not aware of the fluid intervention to have water available in the resident's room and to offer it to the resident each time staff entered the room.

Interview with RPN #116 revealed that staff are expected to be aware and follow the plan of care and confirmed there should have been water in the resident's room as indicated in the plan of care.

Interviews with the DM and RD confirmed that staff should be aware of the plan care of care and are required to implement interventions developed in the plan of care.

A review of the document titled "Minimum Fluid intake required by dietary on daily basis" updated on March 7, 2016, revealed a recommendation for resident #005's required minimum daily fluid requirement.

A review of the progress notes indicated that on an identified date, the resident's fluid intake was less than 50 per cent of the daily fluid requirement for three consecutive days.

A review of resident #005's fluid intake report from point of care revealed that the resident's fluid consumption over that time period was:

Day One: 180 ml
Day Two: 145 ml
Day Three: 845 ml
Day Four: 580 ml
Day Five: 890 ml
Day Six: 800 ml

A review of resident #005's fluid intake report from point of care revealed that the resident's fluid consumption over an identified time period did not meet the minimum daily fluid requirement.

A review of the resident's clinical record revealed that there was no referral sent to RD for the above mentioned fluid intakes.

A review of the home's policy entitled "Resident Rights, Care, and Services-Nutrition Care and Hydration Program-Nutrition Referral Form Policy", revised May 6, 2015, indicated the registered staff will initiate a referral form to notify the FSM or RD of any issues related to the residents nutritional care. Reasons for referrals include fluid standard used is less than 50 per cent of goal fluids intake for three consecutive days after being on stop and watch.

Interview with RPN #116 confirmed referrals to the RD were not sent on an identified date, for the residents having fluid intake less than 50 per cent of the daily fluid requirement. According to the home's policy referrals should have been sent to RD on the above mentioned days.

Interviews with the DM and RD confirmed that they did not receive referrals for the above mentioned days for the resident's poor fluid intake and therefore the resident was not assessed for the risk of dehydration.

Interview with the SE revealed that staff are expected to be aware of the plan of care and to implement it. Staff were educated on the above policy and are expected to implement it.

The severity of the non-compliance and the severity of the harm is Minimal Harm/Risk or Potential for Actual Harm/Risk.
The scope of the non-compliance was isolated to Resident #005.

A review of the Compliance History revealed the following non compliances related to the Long-Term Care Homes Act, 2007, s. 68. (2). Nutrition and Hydration Program, a Written Notification (WN) and a Compliance Order (CO) were previously issued for s. 68. (2), during the inspection # 2015_414110_0002 on February 24, 2015. [s. 68. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from sexual abuse by anyone.

The applicable definition of sexual abuse in O. Reg. 79/10 of the Long-Term Care Homes Act is "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Record review of an identified critical incident (CI) report and progress notes revealed on an identified date, PSW #124 witnessed resident #049 touching an identified area of resident #050's body. The staff member intervened and separated both residents. Resident #050 did not demonstrate any distress after the incident.

Interview with PSW #124 indicated on an identified date and time, he/she observed residents #049 and #050 sitting in the hallway beside each other.
Resident #049's hand was touching an identified area of resident #050's body. The PSW immediately intervened and removed #049 from the area.

Interviews with RN #122 and the DRC indicated resident #050 was unable to give consent and confirmed home has failed to protect resident #050 from sexual abuse. [s. 19. (1)]

2. The licensee has failed to protect residents from verbal abuse by anyone.

The applicable definition of verbal abuse in O. Reg. 79/10 of the Long-Term Care Homes Act is "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Record review of an identified CI report revealed that on an identified date, when PSWs #121 and #123 were providing care to resident #052, the resident asked for an identified item. PSW #121 responded to resident #052's request in a manner that made the resident upset.

A review of resident #052's RAI-MDS assessment revealed the resident had mild cognitive impairment.

Interview with PSW #123 indicated on an identified date he/she and PSW #121 were assisting resident #052 with care. The resident enjoyed keeping an identified item and

this item had fallen to the floor. The resident asked PSW #121 to pick up the identified item for him/her, and overheard PSW #121 respond in an inappropriate manner to the resident. The resident became upset and yelled at PSW #121.

Interview with PSW #121 revealed he/she asked the resident questions about the identified item and when resident #052 responded back, PSW #121 indicated he/she responded in a jokingly manner. He/she indicated the resident was upset because he/she could not pick up the identified item by him/herself, and not because of what he/she said to him/her.

Interview with PSW #121 revealed he/she was frustrated but denied shouting at the resident.

Interviews with PSW #123 and the DRC indicated PSW #121's verbal comments were degrading in nature and diminished the resident's sense of well-being and confirmed the home had failed to protect resident #052 from verbal abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe positioning techniques when assisting residents.

Review of an identified CI report, progress notes and RAI-MDS assessments revealed resident #051 had cognitive and physical impairment, and the resident's primary mode of locomotion was a wheelchair. On an identified date resident #051 repeatedly attempted to enter a co-resident's room while two PSWs were providing care. As a result, PSW #127 aggressively wheeled the resident down the hallway without ensuring the footrests were properly positioned to support the resident's legs on the wheelchair.

Interview with staff #126 indicated that on an identified date, he/she witnessed PSW #127 wheel resident #051 quickly down the hallway without using footrests and the resident's feet were touching the floor while the wheelchair was being pushed.

Interview with PSW #127 confirmed he/she wheeled the resident without using the footrests of the wheelchair.

Interviews with staff #126 and the DRC indicated the safe positioning techniques when assisting the resident in wheelchair during locomotion was to properly position the resident's feet on the footrests of the wheelchair. They confirmed the safe positioning technique was not used for resident #051 during the above mentioned incident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff uses safe positioning techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Record review of an identified CI report and progress notes revealed resident #049 had a history of demonstrating inappropriate responsive behaviours toward residents and staff. On an identified date, resident #049 demonstrated inappropriate responsive behaviours towards resident #050.

Record review of resident #049's assessment records indicated an identified assessment was initiated and completed on an identified date. The resident was referred to the behaviourial support team and a behavioural care plan was recommended. Further review of the progress notes and RAI-MDS assessments indicated resident #049 continued to demonstrate inappropriate responsive behaviours, verbal and physical aggressions after the behavioural care plan was implemented on an identified date.

Interviews with PSW #124, RN #122, SE #135, and the DRC indicated the interventions for managing resident #049's behaviours were ineffective and the resident continued to demonstrate the above mentioned behaviours. Further interviews with RN #122, SE #135 and the DRC confirmed there was no assessment or reassessment completed for the needs of resident #049's behaviours until after the incident on an identified date. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments and reassessments, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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 individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Record review of an identified CI report and progress notes revealed resident #051 had cognitive and physical impairment. On an identified date, resident #051 repeatedly attempted to enter a co-resident's room where two PSWs were providing care. PSW #127 shouted at resident #051 "this isn't your room you need to get out." A few minutes later, resident #051 entered the same room again and PSW #127 aggressively wheeled the resident down the hallway.

Interview with staff #126 indicated on an identified date, he/she heard PSW #127 raise his/her voice and shout at resident #051 to "get out, you can't keep coming into the room." Then the staff member saw PSW #127 wheel resident #051 quickly down the hallway.

Interviews with staff #126 and the DRC indicated PSW #127 shouted at resident #051 and proceeded to quickly wheel the resident down the hallway. They confirmed the resident was not treated with courtesy and respect by PSW #127. [s. 3. (1) 1.]

2. Record review of an identified CI report revealed on an identified date, PSW #121 while responding to resident #053's request to be toileted and the PSW stated to the resident, "you just went 10 minutes ago. I can't do my job if you pull the bell every five minutes." An identified staff member opened the door and offered to take the resident for a walk.

A review of resident #053's RAI-MDS assessment revealed the resident required assistance for toileting.

Interview with staff #125 indicated on an identified date while in the hallway outside of resident #053's room, he/she overheard PSW #121 shouting at the resident that "you just used your washroom, why do you keep asking". Staff #125 interrupted and offered to take the resident for a walk. The resident was upset and asked who was the staff shouting at him/her. Staff #125 later reported the incident to the home.

Interviews with staff #125 and the DRC confirmed since resident #053 was being shouted at by PSW #121, the resident was not treated with courtesy and respect by PSW #121. [s. 3. (1) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

Record review revealed that on an identified date resident #015 was found to have an area of altered skin integrity to an identified area of his/her body. The record further revealed that treatment was provided to the wound and that the physician and the family had not yet been notified. It also indicated on an identified date the resident's family member noticed the dressing on the resident's identified area of the body which had been dated on an identified date. This family member raised a concern regarding this area of altered skin integrity with the staff working that day.

Record review revealed that after the initial treatment provided on an identified date, there was no further wound notes, documentation, referrals, assessments or treatment of the identified area of altered skin integrity. A further review identified the plan of care had not been updated.

Interviews with RN #122, and DRC confirmed that this wound had not been thoroughly documented or assessed when it occurred and as a result there were no revisions made to the resident's plan of care to reflect the changes in the resident's care needs. [s. 6. (10) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated.

Review of an identified CI report involving an allegation of resident to resident abuse was submitted on an identified date.

Review of resident #040 and #041 progress notes indicated resident #040 entered resident #041's bedroom on an identified date and touched an area on resident #041's body without consent. Further review of the notes revealed resident #041 verbalized he/she was afraid and upset by the incident.

Review of the home's investigation and interview with the DRC confirmed the investigation was not initiated until an identified date, five days after the incident occurred. [s. 23. (1) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred must immediately report the suspicion and the information upon which it was based to the Director.

Review of an identified CI reported an alleged incident of staff to resident abuse involving resident #029 that occurred on an identified date, and submitted to the Director at a later identified date.

Interview with Administrator confirmed the incident was not reported immediately to the Director as required. [s. 24. (1)]

2. Review of an identified CI reported an alleged incident of verbal abuse involving resident #055 and an unidentified staff member on an identified date and submitted to the Director at a later identified date.

Interviews with SE #109 and the Administrator confirmed the above mentioned alleged verbal abuse incident was not reported immediately to the Director as required. [s. 24. (1)]

3. Review of an identified CI reported an alleged incident of staff to resident abuse involving resident #016 that occurred on an identified date and submitted to the Director at a later identified date.

Interview with Administrator confirmed the incident was not reported immediately to the Director as required. [s. 24. (1)]

4. Review of an identified CI reported an alleged incident of resident to resident abuse involving resident #041 that occurred on an identified date and submitted to the Director at a later identified date.

Interview with RPN #149 revealed he/she reported the above incident to the management of the home.

Interview with the DRC revealed that the home was aware of the incident on an identified date, but did not notify the Director of the alleged sexual abuse incident until a later identified date. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects that may constitute a criminal offence.

Review of an identified CI reported an alleged resident to resident abuse that occurred on an identified date.

Review of the home's investigation revealed the home contacted the police to report the alleged abuse incident on a later identified date.

Interview with RPN #147 revealed the home's practice is to notify the police immediately for any allegation of abuse that may constitute a criminal offence.

Interview with the DRC confirmed that the police were not immediately notified of the above incident of alleged abuse.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Review of an identified CI report indicated resident #037 fell on an identified date which required transfer to the hospital with an injury. The CI was submitted to the Director on an identified date.

Review of resident #037's progress notes revealed resident fell on an identified date and had verbalized pain upon movement of the identified part of the body. The resident was transferred to the hospital for an assessment.

Interview with the DRC confirmed the home did not submit a CI report until an identified date, and to date has not been amended as required by legislation.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On an identified date the Inspectors observed an unlocked, unattended medication cart that contained residents' prescription medication, outside of the dining room on an identified home area.

RN #122 confirmed that the cart was not locked as required at the time of this observation.

The Administrator confirmed that the medication cart is to be kept locked at all times when not in use. [s. 130. 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the licensee shall ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

On an identified date a complaint was received that alleged the licensee had wrongfully discharged resident #042.

Review of resident #042's plan of care revealed an identified medical condition that contributed to the behaviours exhibited by resident #042.

Review of resident #042's progress notes revealed an entry recorded by the physician

that resident #042 was observed to be angry and threatening towards other residents when he/she was unable to locate a personal possession. Documentation indicated the resident had thrown several objects at other residents,was upset wanting to go the hospital and attempted to call 911.

Review of the physician's notes indicated the resident was transferred to the hospital for an assessment and treatment related to the escalation of the resident's responsive behaviours and potential risk to other residents.

Further review of the progress indicated the home's medical director was contacted by the RAI Coordinator on an identified date requesting a discharge order for resident #042 due to resident's ongoing safety risk to other residents. A discharge order was obtained from the medical director by the (A) DRC on an identified date and time.

On an identified date the progress notes indicated the SDM called to inquire about resident's #042's discharge and indicated the SDM informed the home that it was the hospital who notified him/her of the resident's discharge from the home. Review of the progress notes between an identified date to an identified date did not indicate any documentation that the SDM was notified of the discharge.

The licensee was unable to provide a written notice that was given to the resident or the SDM outlining a detailed explanation of the licensee's decision to discharge the resident. Review of a discharge letter was not available.

Interview with the SDM indicated he/she was notified by the home on an identified date that resident #042 was transferred to the hospital for assessment due to an escalation in the resident's behaviours. SDM indicated he/she was not provided any verbal or written notice that resident #042 was going to be discharged from the home, and was not given the opportunity to be involved in the resident's discharge planning.

Interview with the RAI Coordinator revealed the home requested a discharge order from the medical director on an identified date two days after the resident was transferred to the hospital and confirmed the resident was discharged to the hospital on an identified date.

Interview with the DRC revealed the home discharged the resident due to resident's safety risks to himself and others and that the home had exhausted all their resources and was unable to provide care to the resident. Further interview with the DRC indicated

the plan to discharge had been discussed with the SDM but could not confirm that a discharge letter was sent to the SDM. [s. 148. (2)]

Issued on this 8th day of July, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), CECILIA FULTON (618), MATTHEW CHIU (565), NITAL SHETH (500)
Inspection No. / No de l'inspection :	2016_393606_0006
Log No. / Registre no:	007467-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 22, 2016
Licensee / Titulaire de permis :	BARRIE LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ROBERTA PLACE 503 ESSA ROAD, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carmen Priester

To BARRIE LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_414110_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:

Develop and implement a process to monitor and ensure staff implement the home's Nutritional Referral Form Policy, and send referrals to the Registered Dietitian for resident having fluid intake less than 50 per cent of their target amount as indicated in the plan of care.

Implement a process to monitor and ensure all direct care staff are aware of the contents of the residents' plan of care and to implement it at all times.

Provide education to all direct care staff including new hires about the home's Nutrition Referral Policy and the importance and implementation of the plan of care.

Please submit a compliance plan to nital.sheth@ontario.ca by July 8, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the Nutrition and Hydration Program includes the implementation of interventions to mitigate and manage identified risks.

A review of a previous Compliance Order issued during the 2015 Residents' Quality Inspection (RQI), revealed that the home's hydration program failed to include the identification of any risks related to hydration as there were no clear directions to registered staff on monitoring and evaluating fluid intake and when to identify when a resident has not been consuming enough fluids.

The order was issued to include the identification of any risks related to hydration and the implementation of interventions to mitigate and manage the risks. The following ground revealed that the licensee had failed to comply with the implementation of interventions to mitigate and manage the hydration risk.

- On three identified dates and time, the inspector observed water was not available in resident #003 and #005's room.

A review of resident #003's care plan directed staff to provide water in the resident's room, and to offer to the resident each time staff entered the room.

Interview with PSW #113 revealed that he/she was not aware about the above mentioned fluid intervention for the resident.

Interview with RN #100 confirmed that there was no water in the resident's room and staff were required to be aware of and provide care set out in the plan of care.

Interview with the DM and RD confirmed that staff should be aware of the plan care of care and are required to implement interventions developed in the plan of care.

A review of resident #005's care plan revealed the resident is at risk for dehydration related to altered skin integrity, medication and medical diagnosis. An intervention to increase fluid intake directed staff to provide water in the resident's room and to offer to the resident each time staff entered the resident's room.

Interview with PSW #114 revealed that he/she was not aware of the fluid intervention to have water available in the resident's room and to offer it to the resident each time staff entered the room.

Interview with RPN #116 revealed that staff are expected to be aware and follow the plan of care and confirmed there should have been water in the resident's room as indicated in the plan of care.

Interviews with the DM and RD confirmed that staff should be aware of the plan care of care and are required to implement interventions developed in the plan of care.

A review of the document titled "Minimum Fluid intake required by dietary on daily basis" updated on March 7, 2016, revealed a recommendation for resident #005's required minimum daily fluid requirement.

A review of the progress notes indicated that on an identified date, the resident's fluid intake was less than 50 per cent of the daily fluid requirement for three consecutive days.

A review of resident #005's fluid intake report from point of care revealed that the resident's fluid consumption over that time period was:

Day One: 180 ml
Day Two: 145 ml
Day Three: 845 ml
Day Four: 580 ml
Day Five: 890 ml
Day Six: 800 ml

A review of resident #005's fluid intake report from point of care revealed that the resident's fluid consumption over an identified time period did not meet the minimum daily fluid requirement.

A review of the resident's clinical record revealed that there was no referral sent to RD for the above mentioned fluid intakes.

A review of the home's policy entitled "Resident Rights, Care, and Services-Nutrition Care and Hydration Program-Nutrition Referral Form Policy", revised May 6, 2015, indicated the registered staff will initiate a referral form to notify the FSM or RD of any issues related to the residents nutritional care. Reasons for referrals include fluid standard used is less than 50 per cent of goal fluids intake for three consecutive days after being on stop and watch.

Interview with RPN #116 confirmed referrals to the RD were not sent on an identified date, for the residents having fluid intake less than 50 per cent of the daily fluid requirement. According to the home's policy referrals should have been sent to RD on the above mentioned days.

Interviews with the DM and RD confirmed that they did not receive referrals for the above mentioned days for the resident's poor fluid intake and therefore the resident was not assessed for the risk of dehydration.

Interview with the SE revealed that staff are expected to be aware of the plan of care and to implement it. Staff were educated on the above policy and are expected to implement it.

The severity of the non-compliance and the severity of the harm is Minimal Harm/Risk or Potential for Actual Harm/Risk.
The scope of the non-compliance was isolated to Resident #005.

A review of the Compliance History revealed the following non compliances related to the Long-Term Care Homes Act, 2007, s. 68. (2). Nutrition and Hydration Program, a Written Notification (WN) and a Compliance Order (CO) were previously issued for s. 68. (2), during the inspection # 2015_414110_0002 on February 24, 2015. [s. 68. (2) (c)]

(500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

Service Area Office /
Bureau régional de services : Toronto Service Area Office