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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
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159 rue Cedar Bureau 403
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 20, 2019	2019_771734_0003	033583-18, 000047-19	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

JADY NUGENT (734), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 11-15 and February 19-20, 2019.

The following intake was inspected upon during this Complaint inspection:
-one related to responsive behaviours and
-one related to skin and wound care.

A Critical Incident System intake related to the same issue (responsive behaviours/resident elopement) was also inspected during this Complaint inspection:

Critical Incident System (CIS) inspection #2019_771734_0002 and Follow-up inspection #2019_771734_0004 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and residents.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. 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, strategies were developed, and implemented to respond to those behaviours where possible.

A complaint was received by the Director; whereby, the complainant described an incident in which resident #005 eloped from the home despite the home knowing of the risk of this type of behaviour.

In addition, a Critical Incident System (CIS) report was submitted to the Director for this incident in which resident #005 eloped from the home. According to the report, the resident was last seen by Personal Support Worker (PSW) #125. At a specific time the home received a phone call from community members asking if there was a resident by a certain name to which Registered Nurse (RN) #126 confirmed affirmatively. Information was then obtained that identified the location of resident #005. The resident was later returned to the home.

The health care records for resident #005 were reviewed by Inspector #196. The care plan identified the focus of elopement associated risks and included the intervention of, "If [resident] leaves the unit, [resident] must be supervised by staff".

During an interview with RN #126, they reported to the Inspector that they were working on the Home Area (HA) when resident #005 eloped from the home. The RN added that they were not aware that this resident was at risk for wandering and it had not been communicated at the shift report. They further added that residents were checked on, by the RN and PSW doing hourly or 30 minute checks to, “make sure you have eyes on the resident at least hourly”.

During an interview with Co-Director of Care (Co-DOC) #108, they reported that either the PSW, Registered Practical Nurse (RPN) or RN, were to check on residents hourly; do a visual “life” check, ensure they were present, not trying to get up. They confirmed to the Inspector, that the resident's plan of care was not followed at the time the resident eloped from the home. Specifically, the care plan in effect at the time of the incident indicated that the resident was to be accompanied by staff when off the unit. It was confirmed to Inspector #196 that the resident was not supervised by staff when they left the unit during this incident. [s. 53. (4) (b)]

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 O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, there was, at least quarterly, a documented reassessment of each resident's drug regime.

During a review of resident #005's health care record, Inspector #196 noted that the most recent signed "Physician Medication Review" was dated for the previous quarter. On a clip board on the nursing desk in a HA, was a "Physician Medication Review" document dated for the current quarter, for resident #005, that was not initialed by registered staff, or signed by the physician. The clip board also had "Physician Medication Review(s)" documents dated for the same time period for resident #016, #017, and #018, that had not been initiated by registered staff, or signed by the physician. In addition, a clip board on the nursing desk of another HA, had a "Physician Medication Review" dated for the same time period of, for resident #019.

Inspector #196 identified that, "Physician Medication Review(s)", did not have initials of the registered staff to indicate that a first or second review had been completed, nor a physician's signature.

During an interview with RPN #104, from a specified HA, they reported that the pharmacy would send the quarterly reviews to the home and the registered staff were to check the electronic medication administration record (e-mar) and the physician orders to ensure they were correct. The RPN then confirmed the quarterly review for resident #019, dated for the current quarter, had not yet been checked by registered staff or signed by the physician. They further confirmed the physician orders being followed for resident #019 were from the last quarter. They added that the reason the new quarterly review had not yet been checked and signed was due to time constraints; also, there was a new RN on night shift and they were still learning, and there was no time to complete the review on this day.

During an interview with Co-DOC #108, they reported that the,"Physician Medication Review", was to be checked by the registered staff; then the physician either re-orders, discontinued or holds the medications and/or treatments, may make notes, or adjust dosages on this review every three months.

During a further interview, Co-DOC #108 confirmed to Inspector #196, after a review of the "Physician Medication Review(s)", for resident #005, #016, #017, #018 and #019, that all of the quarterly reviews that were in use were dated for the previous time period; the new quarterly reviews that were to be signed had not been checked by the registered staff or signed by the physician.

During an interview with the pharmacy service provider, Pharmacist consultant #127, reported that the "Physician Medication Review" were to be completed every three months. They further reported they would try to send the reviews out to the home approximately two weeks prior to the date of the quarterly review which provided time to do the checks and have the physician sign the reviews. The pharmacy continued to issue the medications as indicated on the previous review, whether or not the new quarterly review had been received back signed by the physician. They added that there was a clause, "The Continued Care Clause", written on the review to authorize all of the listed and interim orders for four months or until the completion of the next physician medication review. They further explained the reason for the clause, was in the event the physician was unable to sign the reviews and if the Ontario College of Pharmacists were to inspect them.

During an interview with the DOC #102, they acknowledged that the last quarterly review for resident #005 was dated for a specified previous date relating to the previous quarter.

Together with the Inspector, the pharmacy service provider policy was reviewed; the DOC acknowledged that the policy read "Physician Medication Reviews are provided to Long Term Care homes on a quarterly basis (and typically complemented by a Pharmacist Assessment Summary)". However, they added that Co-DOC #108 had initiated audits of the resident's quarterly medication reviews to determine the need for completion. [s. 134. (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 that ensures that, there is at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	JADY NUGENT (734), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2019_771734_0003
Log No. / No de registre :	033583-18, 000047-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 20, 2019
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
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 :	Megan Merz

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 53 (4) (b).

The licensee shall ensure that resident #005 and all other residents will have strategies implemented that minimize the risk of elopement. Specifically, the licensee will develop and implement a process to facilitate communication amongst staff members to minimize the risk of resident elopement.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed, and implemented to respond to those behaviours where possible.

A complaint was received by the Director; whereby, the complainant described an incident in which resident #005 eloped from the home despite the home knowing of the risk of this type of behaviour.

In addition, a Critical Incident System (CIS) report was submitted to the Director for this incident in which resident #005 eloped from the home. According to the report, the resident was last seen by Personal Support Worker (PSW) #125. At a specific time the home received a phone call from community members asking if there was a resident by a certain name to which Registered Nurse (RN) #126 confirmed affirmatively. Information was then obtained that identified the location

of resident #005. The resident was later returned to the home.

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During an interview with Co-Director of Care (Co-DOC) #108, they reported that either the PSW, Registered Practical Nurse (RPN) or RN, were to check on residents hourly; do a visual “life” check, ensure they were present, not trying to get up. They confirmed to the Inspector, that the resident's plan of care was not followed at the time the resident eloped from the home. Specifically, the care plan in effect at the time of the incident indicated that the resident was to be accompanied by staff when off the unit. It was confirmed to Inspector #196 that the resident was not supervised by staff when they left the unit during this incident.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of this issue was a level 1, as it was an isolated event. The home had a level 3 history of non-compliance as they had a previous non-compliance with this section of the LTCHA that included:
-a Voluntary Plan of Correction (VPC) issued June 22, 2016 (2016_393606_0006) (734)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jady Nugent

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