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

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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
May 14, 2019	2019_805638_0012	002917-19, 003451-19	Critical Incident System

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 6 - 10, 2019.

The following intakes were completed in this critical incident system inspection:
-One log was related to an incident of resident to resident abuse; and

-One log was related to an alleged incident of neglect.

A follow up inspection #2019_805638_0013 was conducted concurrently with this critical incident system inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIS report was submitted to the Director related to an incident of resident to resident abuse that occurred on a specific date in 2019. The report outlined an incident where resident #001 demonstrated specific responsive behaviours towards resident #002.

Inspector #638 observed resident #001 demonstrating a specific behaviour during the inspection. RPN #102 responded to the resident when they began demonstrating the specific behaviour. The RPN identified to the Inspector that this specific behaviour was a sign that the resident was becoming agitated and that this approach was to minimize risk of escalation of any behaviours towards other residents.

The Inspector reviewed resident #001's health care records and identified in their most recent Minimum Data Set (MDS) assessment that the resident demonstrated specific types of responsive behaviours one to three days in the seven day assessment period.

Inspector #638 reviewed resident #001's current care plan and identified a foci which identified a specific response to specific triggers. However, the Inspector was unable to identify, in the care plan, any indication that the resident had the potential to demonstrate the specific types of responsive behaviours (documented in the CIS report to the Director) identified.

The Inspector identified in the progress notes, that resident #001 also demonstrated a

specific type of responsive behaviour towards four other residents on five occassions. On one occasion the responsive behaviours resulted in an injury to a resident.

Inspector #638 reviewed a referral form for an external agency which was sent on a specific date in 2018, which identified that resident #001 was referred due to concerns related to resident safety as a result of their specific responsive behaviours.

The Inspector reviewed resident #001's health care records and identified a specific assessment signed on a specific date in 2018, which outlined that change was a trigger for resident #001 and they had an episode of specific responsive behaviours.

In an interview with Inspector #638, PSW #101 indicated that they referred to the electronic kardex or care plan for resident specific information. PSW #101 indicated that resident #001 may become agitated towards other residents, but specific responsive behaviours usually occurred at a specific time during the day. The PSW stated that specific types of behaviours were identified in the care plan to keep staff aware of risks.

During an interview with Inspector #638, RPN #103 indicated that direct care staff referred to the electronic kardex and care plan for resident specific information, including specific types of responsive behaviours. The RPN indicated that resident #001 would automatically display specific responsive behaviours if a resident triggered them. RPN #103 indicated that the resident demonstrated a specific type of responsive behaviours "probably weekly". The Inspector reviewed resident #001's care plan with RPN #103, who stated that the specific types of behaviours demonstrated by the resident should have been identified in the plan.

The home's policy titled "Resident Rights Care and Services – Plan of Care" last revised March 13, 2018, indicated that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other.

In an interview with Inspector #638, the Administrator described resident #001's characteristics and the specific type of responsive behaviours were not a common trend. The Inspector reviewed, with the Administrator, the aforementioned progress notes and current care plan, to identify the frequency in which the resident displayed the specific type of responsive behaviours, as well as, what was identified as the potential types of responsive behaviours the resident demonstrated, in the care plan. Upon review, the

Inspector inquired if they would expect specific behaviours be identified in the plan of care, the Administrator stated that they would "want to identify all behaviours in the care plan". [s. 6. (4) (b)]

Issued on this 15th day of May, 2019

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

Original report signed by the inspector.