Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_746692_0015	003792-20, 005801-20, 011716-20, 011964-20	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

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): July 6-10, 2020.

The following intake(s) were inspected upon during this Critical Incident System Inspection:
-Four logs, which were related to critical incidents that the home submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to the hospital, resulting in a significant change in the resident's health status.

The following CIS intake related to the same concerns (staff to resident physical abuse) was completed during Complaint inspection #2020_746692_0013.

A Complaint Inspection #2020_746692_0013 and a Follow Up Inspection #2020_746692_0014 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Staff Educator, Restorative Care Coordinator (RCC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care was provided to the resident as specified in the plan of care.

A Critical Incident (CI) report was submitted to the Director for a fall that resulted in an injury that occurred on an identified date. The CI report indicated that staff responded to resident #003's call for assistance and found the resident sitting on the floor, the resident had sustained an identified injury, and was transferred to the hospital.

Inspector #690 reviewed resident #003's electronic care plan that was in place at the time of the incident, which indicated that the resident was at moderate risk of falling and staff were to ensure that an identified intervention was in place at a specified time.

In an interview with resident #003, they indicated to Inspector #690 that they recalled the above mentioned incident when they had fallen sustaining an injury and had to be sent to the hospital. They could not recall if they had the identified intervention in place at the time that they had fallen, but indicated to the Inspector that they used to have the identified intervention in place; however, they had not had it for a long time. The resident further indicated that they were afraid to fall again, that they required the assistance of staff to implement the identified intervention, and thought that having the identified intervention at a specified time was a good idea. In a later interview with Inspector #690, resident #003 indicated that they had approached the Restorative Care Coordinator (RCC) after speaking to the Inspector and had requested the identified intervention be put back in place.

In separate interviews with Personal Support Workers (PSWs) #102 and #105, they indicated to Inspector #690 that resident #003 was at risk of falling, and that they required the assistance of staff to implement the identified intervention. PSW #102 indicated that they had recalled seeing the identified intervention in place for resident #003 in the past, but had not in a while.

During an interview with Inspector #690, Registered Practical Nurse (RPN) #108, they indicated that they were working the shift that resident #002 fell and was sent to the hospital. RPN #108, could not recall if the resident had the identified intervention in place at the time of the fall. In a separate interview with RPN #110, they indicated that resident #003 was at risk of falling and had fall interventions in place to prevent further falls. Together, Inspector #690, and RPN #110, viewed the resident's care plan on Point Click

Care (PCC), and RPN #110 indicated that staff were to ensure that the resident had the identified intervention in place at a specified time.

In an interview with the RCC, they indicated to Inspector #690 that resident #003 was at moderate risk of falling and that staff were to ensure that the resident had the identified intervention in place at a specified time. The RCC indicated to the Inspector that resident #003 had approached them and requested that the identified intervention be put in place again. The RCC further indicated that there was a supply of the identified intervention for staff to access on each home area if a resident required it.

In an interview with the Director of Care (DOC), they indicated to Inspector #690 that resident #003 was at a moderate risk of falling and had fall prevention interventions in place to prevent falls. Together, the Inspector and the DOC viewed the resident's care plan and the DOC indicated that staff were to ensure that the identified intervention was in place at a specified time. The DOC further indicated that if staff were not ensuring that the identified intervention was in place, then care was not provided to the resident as specified in the care plan. [s. 6. (7)]

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 ensuring that care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

Issued on this 24th day of July, 2020

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

Original report signed by the inspector.