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
Nov 23, 2016	2016_168202_0015	022718-16	Resident Quality Inspection

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET BARRIE ON L4N 5L3

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

VALERIE JOHNSTON (202), JENNIFER BROWN (647), JOVAIRIA AWAN (648), KAREN MILLIGAN (650), NATALIE MOLIN (652), NICOLE RANGER (189), SUSAN SEMEREDY (501)

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): July 27, 28, 29, August 02, 03, 04, 05, 08, 09, 10, 11, 12, 15, 16, 17, 18, 19, 2016.

During the course of the inspection the following Critical Incident Inspections were completed:

-Staff to resident abuse: 006159-16, 010505-16, 022565-16.

-Resident to resident abuse: 009244-16.

-Resident was found wandering outside of property: 018315-16.

-Fall with fracture: 020608-16.

During the course of the inspection the following Complaint Inspections were completed:

-Fall with fracture: 019591-16, 020135-16.

-Availability of supplies, medication administration, continence care, lack of snacks and availability of food, shortage of staff: 004584-16.

During the course of the inspection 12 Follow-up Inspections were completed:

-013238-16, 012899-16.

During the course of the inspection the inspector (s): reviewed clinical records, conducted a tour of the home, observed lunch meal service and medication administration, reviewed home's policies related to falls prevention, skin and wound care, continence care, responsive behaviours, reviewed Residents' Council and Family Council meeting minutes, staffing schedule, employee files.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Director of Food Services (DFS), Director of Environmental Service (DES), Environmental Service Coordinator (ESC), Director of Program Support/Volunteer Services, Restorative Care Coordinator, Nurse Practitioner (NP), Human Resource Manager, Director of Human Resources, Resident Care Administration Assistant, Housekeeping Staff, Food Service Workers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Activationists, Personal Support Workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing
Training and Orientation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_336620_0009	202
O.Reg 79/10 s. 221. (1)	CO #004	2016_336620_0008	652
O.Reg 79/10 s. 221. (1)	CO #007	2016_336620_0009	648
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2016_336620_0009	650
O.Reg 79/10 s. 30. (1)	CO #008	2016_336620_0009	650
O.Reg 79/10 s. 31. (3)	CO #005	2016_336620_0009	202
O.Reg 79/10 s. 53. (3)	CO #002	2016_336620_0008	650
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_336620_0008	652

O.Reg 79/10 s. 72. (3)	CO #003	2016_336620_0008	501
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #003	2016_336620_0009	648
O.Reg 79/10 s. 8. (1)	CO #004	2016_336620_0009	501
O.Reg 79/10 s. 99.	CO #006	2016_336620_0009	648

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol and procedure instituted or otherwise put in place was complied with.

During stage 1 of the Resident Quality Inspection (RQI), resident #007 triggered for a fall. Record review indicated that on an identified date, PSW #164 entered the resident's room to respond to a bed alarm. As PSW #164 entered the room, resident #007 fell on the floor.

A review of the home's policy on fall preventions and management titled "Falls Assessment and Follow up" dated May 5, 2016, revealed that after a fall, registered staff were expected to conduct an initial follow up with a "Post Fall Note" every shift for 24 hours.

A review of resident #007's clinical record related to the fall revealed a Post Fall Note was not documented as required.

Interview with RPN #113 and ADOC#112 confirmed that it is the home's expectation that a Post Fall note is completed for every fall experienced by a resident, and that the registered staff did not follow the home's policy related the fall incident that occurred as mentioned above. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the home's policy on fall preventions and management titled, Falls Assessment and Follow-up, #RC 12-01-02, dated May 5, 2016, revealed that after a resident has fallen, registered staff are to complete the "Post Fall Note" every shift for 24 hours and in the event of a known or potential head injury are to complete the "Post Fall Note" every shift for 48 hours.

Review of resident #020's record revealed he/she had a fall on an identified date. There was only one post fall note documented. Interview with NM #139 confirmed that a post fall note had only been completed once for the above mentioned fall, and the home was therefore not following their policy regarding post fall notes.

Interviews with registered staff indicated they were aware that post fall notes were to be completed but some were unsure for how long the monitoring and documenting should occur. Interview with RPN #126, 151 and NM #139 thought that post fall notes were to be made every shift for 72 hours. Interview with NM #139 confirmed that staff need to be re-

educated regarding post fall assessments.

Interview with ADOC and Director of Program Support confirmed that for resident #020 a post fall note was not completed every shift for 24 hours and the home had not followed their Fall Assessment and Follow-up policy.

The severity of the non-compliance and the severity of the harm and risk of further harm is potential. The scope of the non-compliance is isolated to residents #007 and #020.

A review of resident #007's and #020's clinical records indicated that both resident's had fallen in the home. Record review and staff interviews confirmed the above mentioned falls and that a "Post Fall Note" had not been completed for every shift for 24 hours as directed by the home's policy, titled, Falls Assessment and Follow-up, #RC 12-01-02, dated May 5, 2016.

The home has previously been issued a Compliance Order, under LTCHA, 2007,. O. Reg 79/10. S. 8 (1) b, on April 15, 2016, within report #2016_336620_0009, specifically related to the home's Fall Prevention and Management policy. [s. 8. (1) (a),s. 8. (1) (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 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The home submitted a Critical Incident System (CIS) report on an identified date. The CIS report indicated resident to resident abuse whereby resident #061 had alleged that resident #060 had hit him/her.

A review of resident #060's clinical records indicated that resident #060 had been identified with responsive behaviours that included inappropriate actions towards residents and staff. The progress notes for resident #060 were reviewed for an identified period of time and revealed that on an identified date, resident #060 had been witnessed by staff to enter resident #061's room and an altercation occurred.

An interview with RN #140 revealed that he/she had witnessed the altercation between resident #060 and resident #061 and identified the above incident as physical abuse. The RN revealed that following the incident, resident #061 had complained of a sore identified area of the body with no apparent bruising. The progress notes dated two days post the witnessed incident date, revealed bruising to an identified area of the resident's

body. RN #140 confirmed that the witnessed incident of abuse had not been reported to the home or to the Ministry of Health and Long-Term Care Director.

An interview with the ADOC indicated that he/she only became aware of the above mentioned witnessed incident of abuse when resident #061 had reported approximately one month later that he/she had been physically abused by resident #060. The ADOC confirmed that the witnessed physical abuse that occurred between resident #060 and resident #061 had not been reported to the Director as required by the legislation.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

On an identified date resident #061 alleged that resident #060 had struck him/her. In response to the allegation the home investigated and found that resident #061 had been subject to physical abuse by resident #060 approximately one month earlier. The physical abuse that had been confirmed and witnessed by RN #140 on the initial identified date, had not been reported to anyone, nor investigated by the home.

The scope of the non-compliance is isolated to residents #060 and #061.

The home has previously been issued a Compliance Order, under LTCHA, 2007,. c.8, s. 24 (1), on April 15, 2016, within report #2016_336620_0009. The home was ordered to ensure a person who has reasonable grounds to suspect that 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 is to immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that:

1. All doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked.

The home submitted a CIS on an identified date indicating that resident #051 had been observed wandering down the road.

A record review of the home's door activity report for the identified incident date indicated that an identified stair well door had been forced open and the door alarm had been reset at an identified time.

An interview with direct care staff indicated that when the door alarm had sounded, resident occupancy had only been checked on the first floor to ensure all residents had been present, however; the other home areas did not perform a resident occupancy check because they were not alerted that the front door alarm had been activated and had been required to be reset.

Interview with the Environmental Services Supervisor (ESS) indicated that it had been identified that resident #051 had been able to force an identified stair well door open on the identified date, due to two magnetic plates not being adjusted to ensure connectivity to the resident-staff communication response system.

Interview with the Administrator further confirmed that the two magnetic plates had not been engaged properly and that there had not been a system in place to ensure the magnetic plates had been functioning therefore the resident had been able to open the door and exit the building without alerting staff.

During the course of the inspection, inspector #647 observed the door access control system consisted of two magnetic plates attached to the top of the door that operated in conjunction with a key pad. The door had been tested for function and connectivity to the resident-staff communication and response system. The key pad was activated and the magnets released temporarily and allowed the doors to be used for entry or exit. The magnets had then reset and secured the door to be used for entry or exit. [s. 9. (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:
1. All doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked., to be implemented voluntarily.

WN #4: 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 failed to ensure that all residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long Term Care Homes Act, 2007. O. Reg 79/10 defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident System (CIS) report on an identified date, indicating that resident #061 had been subject to physical abuse by resident #060.

A review of resident #060's clinical records indicated that the resident had been identified with responsive behaviours that included inappropriate actions towards residents and staff. The progress notes for resident #060 were reviewed for an identified time period, and revealed that on an identified date, resident #060 had been witnessed by staff to enter resident #061's room and an altercation occurred.

An interview with RN #140 revealed that he/she had witnessed the altercation that occurred between resident #060 and resident #061 and identified the incident as physical abuse. RN #140 stated that resident #060 kicked resident #061. The NP confirmed that the kick had resulted in injury to resident #061.

Interview with both the Nurse Manager and the ADOC confirmed that the witnessed incident that occurred on the identified date between resident #060 and resident #061 was resident to resident physical 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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation on July 27, 2016, at lunch in an identified dining room revealed PSW #135 and student PSW #136 did not wash or sanitize their hands between picking up dirty dishes and serving plated food. Interview with both staff members revealed they were aware they should have washed or sanitized their hands after touching dirty plates and serving plated food.

Interview with the Director of Food Services confirmed that the home's expectation is that staff follow hand hygiene practices between handling dirty dishes and clean dishes. [s. 229. (4)]

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 participate in the implementation of the infection and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

The licensee submitted a CIS report on an identified date, to the Director, identifying an allegation of staff to resident neglect

Interview with PSW #153 revealed he/she arrived to an identified home area at an identified date and time. PSW #153 stated that six call bells were activated, and he/she observed PSW #142 and #154 not answering the call bells. PSW #153 described this incident as staff to resident neglect, and reported the incident to RN #138. PSW #153 confirmed that he/she did not report the alleged incident of staff to resident neglect immediately to supervising staff at the home and acknowledged that he/she was aware that he/she should have done so.

Review of the home's Zero Tolerance for Abuse and Neglect Policy No. RC 01-00-01, effective May 4, 2016, acknowledged that suspected, alleged, or witnessed abuse or neglect of a resident by a staff member must immediately be reported to the home's management.

Record review of the home's Mandatory Reporting and Whistle Blowing Protection Policy No. RCAM 6-00, effective May 4, 2016, acknowledged section 24 (1) of the LTCH and instructed the following:
- staff should immediately report through this policy any conduct or events that may lead to a mandatory immediate report under section 24 (1).

Record review of the home's critical incident report indicated the above described incident occurred on an identified date and was reported to RN #138 by PSW #153 two days later. The report to the Director was submitted two days day after the initial incident.

Interview with the DOC confirmed PSW #153 had not reported the above incident immediately as required per the home's policy. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a process to report and locate residents' lost clothing and personal items.

Interviews with residents #001, 004 and 006 revealed that they have had missing clothing and have reported these items as missing to staff. Resident #004's missing items were never recovered.

Interviews with PSWs #104, 111, and 124 revealed that each followed a different procedure to report and locate missing clothing. PSW #104 stated that they report the missing items to the registered staff who sends an email to the Environmental Service Coordinator who then conducts a search. PSW #111 stated they look for the missing item and search other resident rooms and then report to registered staff. PSW #124 stated they look in other resident rooms and then go down to the laundry to look.

Interviews with RPNs #125, 120, and 126 revealed that each followed a different procedure to report and locate missing clothing. RPN #125 stated that they will inform laundry and also may go down to check in the laundry themselves. RPN #120 stated they first do a room search, then send an email to laundry and then go down to laundry to look themselves. RPN #126 stated that they send an email to laundry, then an email to their supervisor while staff search the unit.

Interview with the Environmental Service Coordinator who is the lead for laundry services revealed he/she was unsure if the home had a policy to report and locate missing clothing. He/she stated that when an item is missing the staff first check on the unit and if it remains lost, they will email him/her. He/she recalled that for resident #006 the missing clothing was found but was unaware of the missing items for resident #001 and 004 and could not locate emails regarding any of these missing items.

Review of the home's policy #03-00-07 titled Laundry Procedures: Lost and Found effective August 18, 2006, revealed there is a Laundry Lost and Found Form which is to be filled out by anyone finding or missing an item. The laundry aide will be responsible for updating all forms on a weekly basis. Interviews with all the above mentioned staff revealed the home does not use this form. Interview with the Director of Environmental Services confirmed that there is no formal procedure for reporting or locating missing clothing and the above mentioned policy needs to be updated. [s. 89. (1) (a) (iv)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the plumbing fixtures, including toilets, are maintained.

Observation completed on July 29 and August 9, 2016, revealed that the toilet bowl in the shared washroom of two identified rooms were black as though the porcelain finish had been removed. Interview with resident #004 revealed he/she thought it had been like that ever since he/she was admitted several months ago. Resident #004 stated he/she would like to have a new toilet or have one that was not all black.

Interview with housekeeper #128 revealed this toilet has been discoloured for some time and he/she believed it may have been cleaned inappropriately at some point which caused the porcelain to come off. Interviews with housekeeper #128 and PSW #104 revealed they could use an electronic maintenance reporting system to report such issues but had failed to so for the above mentioned toilet.

Interview with the DES who just started working in the home, revealed he/she was unaware there was an issue with this toilet. He/she checked the maintenance care log and could not find any report regarding this toilet. The DES was unsure how often the home performed maintenance audits but did find a blank audit sheet that showed that toilets are audited. Previous audit sheets could not be found at the time of this inspection. The DES confirmed that a procedure to maintain the toilet in the shared washroom of the identified rooms had not been implemented. [s. 90. (2) (d)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

Interviews with residents #003, 006, and 010 revealed that each of them had missing property items which had been reported to staff. Resident #003 had lost an identified item with money in the form of coins just a few weeks ago. Resident #006 had lost an identified amount of money from his/her wallet/purse when he/she first moved in and the police had been involved. Resident #010 lost an identified item and money from his/her wallet/purse about a month ago.

Interviews with PSWs #104, 111, 125 revealed that the procedure in the home for missing property is for PSWs to search for the item, report to registered staff and communicate through report. Interviews with RPNs #119, 120 and 126 revealed the process in the home is for RPNs to report lost items to their supervisor via email. None of the above staff were aware of a policy to deal with missing property and could not recall any details regarding the above mentioned missing items.

Interview with the DOC revealed that when residents report missing items it is considered a complaint which should be documented, followed up, responded to and tracked for quality improvement purposes. The DOC confirmed that the home has not been treating missing property as a complaint and therefore had no documentation regarding the outcome of the reported missing items for residents #003, 006 and 010. [s. 101. (2)]

2. The licensee has failed to ensure that the documented record of complaints received has been reviewed and analyzed for trends.

Review of the home's complaint binder revealed that only written complaints were being formally kept in a binder and there was no record that these were reviewed and analyzed for trends. Interview with the DOC confirmed that the home has not been reviewing and analyzing verbal and/or written complaints. [s. 101. (3)]

Issued on this 9th day of December, 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) :	VALERIE JOHNSTON (202), JENNIFER BROWN (647), JOVAIRIA AWAN (648), KAREN MILLIGAN (650), NATALIE MOLIN (652), NICOLE RANGER (189), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2016_168202_0015
Log No. / Registre no:	022718-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 23, 2016
Licensee / Titulaire de permis :	IOOF SENIORS HOMES INC. 20 Brooks Street, BARRIE, ON, L4N-5L3
LTC Home / Foyer de SLD :	ODD FELLOW AND REBEKAH HOME 10 BROOKS STREET, BARRIE, ON, L4N-5L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Doreen Saunders

To IOOF SENIORS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall upon receipt of this order:

1. Review the home's policy #RC 12-01-02 titled Fall Assessment and Follow-up effective May 5, 2016, with all registered staff with a specific focus on Post Fall Notes for the required time frames as indicated in the identified home policy.

2. Develop and implement a quality improvement process to audit and analyze the level of compliance by the registered staff to the home's Fall Assessment and Follow-up policy as it relates to the completion of Post Fall notes.

3. This quality improvement process shall include monitoring activities to ensure Post Fall Notes are completed for the required time frames by the registered staff following a fall incident.

4. Ensure a written record is maintained to identify incidents when staff fail to adhere to the home's Fall Assessment and Follow-up Policy that includes what actions were taken to respond to these identified occurrences.

5. The Licensee shall prepare, submit and implement a plan for complying with Orders 1 - 4 and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with. The plan is to be submitted to susan.semeredy@ontario.ca by December 31, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol and procedure instituted or otherwise put in place was complied with.

During stage 1 of the Resident Quality Inspection (RQI), resident #007 triggered for a fall. Record review indicated that on an identified date, PSW #164 entered the resident's room to respond to a bed alarm. As PSW #164 entered the room, resident #007 fell on the floor.

A review of the home's policy on fall preventions and management titled "Falls Assessment and Follow up" dated May 5, 2016, revealed that after a fall, registered staff were expected to conduct an initial follow up with a "Post Fall Note" every shift for 24 hours.

A review of resident #007's clinical record related to the fall revealed a Post Fall Note was not documented as required.

Interview with RPN #113 and ADOC#112 confirmed that it is the home's expectation that a Post Fall note is completed for every fall experienced by a resident, and that the registered staff did not follow the home's policy related the fall incident that occurred as mentioned above. (501)

2. Review of the home's policy on fall preventions and management titled, Falls Assessment and Follow-up, #RC 12-01-02, dated May 5, 2016, revealed that after a resident has fallen, registered staff are to complete the "Post Fall Note" every shift for 24 hours and in the event of a known or potential head injury are to complete the "Post Fall Note" every shift for 48 hours.

Review of resident #020's record revealed he/she had a fall on an identified date. There was only one post fall note documented. Interview with NM #139 confirmed that a post fall note had only been completed once for the above mentioned fall, and the home was therefore not following their policy regarding post fall notes.

Interviews with registered staff indicated they were aware that post fall notes were to be completed but some were unsure for how long the monitoring and documenting should occur. Interview with RPN #126, 151 and NM #139 thought that post fall notes were to be made every shift for 72 hours. Interview with NM

#139 confirmed that staff need to be re-educated regarding post fall assessments.

Interview with ADOC and Director of Program Support confirmed that for resident #020 a post fall note was not completed every shift for 24 hours and the home had not followed their Fall Assessment and Follow-up policy.

The severity of the non-compliance and the severity of the harm and risk of further harm is potential. The scope of the non-compliance is isolated to residents #007 and #020.

A review of resident #007's and #020's clinical records indicated that both resident's had fallen in the home. Record review and staff interviews confirmed the above mentioned falls and that a "Post Fall Note" had not been completed for every shift for 24 hours as directed by the home's policy, titled, Falls Assessment and Follow-up, #RC 12-01-02, dated May 5, 2016.

The home has previously been issued a Compliance Order, under LTCHA, 2007,. O. Reg 79/10. S. 8 (1) b, on April 15, 2016, within report #2016_336620_0009, specifically related to the home's Fall Prevention and Management policy. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall upon receipt of this order:

1. Review the home's policy, titled, Zero Tolerance for Abuse and Neglect, #RC 01-00-01, dated May 4, 2016, with all staff in the home.

2. The home to complete attendance records for the review of the Abuse policy.

3. The policy review shall include, mandatory reporting of abuse under section 24 (1) of the Act and all areas of abuse, including corresponding definitions as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

4. At the end of the review, staff shall be able to recognize and define all forms of abuse under the legislation, and the immediate reporting of such.

5. The Licensee shall prepare, submit and implement a plan for complying with Orders 1 - 4 and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with.
The plan is to be submitted to karen.milligan@ontario.ca by December 31, 2016, and implemented by February 28, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The home submitted a Critical Incident System (CIS) report on an identified date. The CIS report indicated resident to resident abuse whereby resident #061 had alleged that resident #060 had hit him/her.

A review of resident #060's clinical records indicated that resident #060 had been identified with responsive behaviours that included inappropriate actions towards residents and staff. The progress notes for resident #060 were reviewed for an identified period of time and revealed that on an identified date, resident #060 had been witnessed by staff to enter resident #061's room and an altercation occurred.

An interview with RN #140 revealed that he/she had witnessed the altercation between resident #060 and resident #061 and identified the above incident as physical abuse. The RN revealed that following the incident, resident #061 had complained of a sore identified area of the body with no apparent bruising. The progress notes dated two days post the witnessed incident date, revealed bruising to an identified area of the resident's body. RN #140 confirmed that the witnessed incident of abuse had not been reported to the home or to the Ministry of Health and Long-Term Care Director.

An interview with the ADOC indicated that he/she only became aware of the above mentioned witnessed incident of abuse when resident #061 had reported approximately one month later that he/she had been physically abused by resident #060. The ADOC confirmed that the witnessed physical abuse that occurred between resident #060 and resident #061 had not been reported to the Director as required by the legislation.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

On an identified date resident #061 alleged that resident #060 had struck him/her. In response to the allegation the home investigated and found that resident #06 had been subject to physical abuse by resident #060 approximately one month earlier. The physical abuse that had been confirmed and witnessed by RN #140 on the initial identified date, had not been reported to anyone, nor investigated by the home.

The scope of the non-compliance is isolated to residents #060 and #061.

The home has previously been issued a Compliance Order, under LTCHA, 2007,. c.8, s. 24 (1), on April 15, 2016, within report #2016_336620_0009. The home was ordered to ensure a person who has reasonable grounds to suspect that 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 is to immediately report the suspicion and the information upon which it is based to the Director. (650)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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 23rd day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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