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 le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2018;	2018_634513_0001 (A1)	027452-17	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

IOOF Seniors Home
10 Brooks Street BARRIE ON L4N 5L3

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

JUDITH HART (513) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The due date for the order LTCH Act section 6(7) was revised to May 7, 2018.

Issued on this 14 day of February 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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10 Brooks Street BARRIE ON L4N 5L3

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

JUDITH HART (513) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 17, 18, 19, 22, 23, 24, 25 and 26, 2018.

The following critical incidents were inspected concurrently with this inspection:

#006212-17 (C525-000004-17) related to fall prevention and management; and

#011511-17 (C525-000009-17) related to fall prevention and management.

The following Compliance Orders were were inspected concurrently with this inspection:

#034210-16 related to Falls, and Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with residents, families, substitute decision makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Director of Resident Care (DOC), Assistant Director of Resident Care (ADRC), Housekeeper, Family Council President, Family Council Chairperson and Restorative Care Coordinator.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observation of care delivery processes including medication administration, meal delivery service, and review of the home's

policies and procedures and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Residents' Council

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 24. (1)	CO #002	2016_168202_0015	647
O.Reg 79/10 s. 8. (1)	CO #001	2016_168202_0015	647

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 the care set out in the plan of care had been provided to the resident as specified in the plan.

On a specified date in 2017, the home submitted Critical Incident System (CIS) report related to an incident that caused an injury to a resident, for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS indicated resident #022 attempted an activity of daily living and had an unwitnessed incident. The resident was transferred to the hospital and was diagnosed with a medical condition.

A review of the progress notes on a specified date indicated resident #022 experienced an incident and called out. The resident was attended by Registered Practical Nurse (RPN) #113 and Personal Support Worker (PSW) #112. Upon arrival, resident #022 was found lying in a specific position and identified a specific injury occurred. The resident was assessed and experienced pain to a specific location, which could not be moved. The resident was not moved and the paramedics were called to bring the resident to the hospital for further evaluation. The Substitute Decision Maker (SDM) was called and indicated resident #022 had been admitted in the hospital with a specified injury that required a specific treatment. The resident returned to the home on a specified date.

A review of resident #022's written plan of care on a specified date identified them at high risk for falls related to unsteady gait due to medical conditions. The written plan of care directed staff to ensure that resident #022 wear proper and non-slip footwear, ensure their environment is well-lit and clutter free, and that their bed alarm sensor pad is in place and in working order.

The inspector attempted to interview resident #022, however, the resident had been discharged from the home.

Interviews with PSW #112 and RPN #113 indicated that on a specified date in

2017, they both heard resident #022 call out from the bedroom. The PSW and the RPN attended to the resident. RPN #113 stated that there were no changes to the resident's level of consciousness, however, it was apparent that the resident was in extreme pain. Both staff stated that the resident had an identified mechanical intervention in place as part of their plan of care, but did not hear the identified intervention sound at the time of the incident. They further indicated that resident #022 was known to turn off the identified intervention by themselves. PSW #112 indicated that the PSWs would usually make sure the identified intervention was in the on position at the beginning of the shift, during the standard hourly checks of the resident, and before the end of the shift. PSW #112 and RPN #113 could not recall checking to ensure resident #022's the identified intervention was in place and in working order during that specific shift. Both staff confirmed that they did not hear the intervention sound at the time of the incident. The PSW and the RPN acknowledged that in the above mentioned incident, care had not been provided to resident #022 as specified in the plan as it relates to the staff ensuring that the identified intervention was in place and in working order.

An interview with the Director of Resident Care (DOC) acknowledged the above mentioned information and could not demonstrate to the inspector how the staff ensured that resident #022's identified intervention was in place and in working order prior to the incident. The DOC further indicated that the home's expectation was for the staff to provide care to the resident as outlined in the written plan of care.

The severity of the non-compliance was actual harm. The scope of the non-compliance was isolated to resident #022. A review of the home's compliance history within the last three years revealed a Voluntary Plan of Correction (VPC) was previously issued for a noncompliance related to the Long-Term Care Homes Act, 2007, s. 6 (7). [s. 6. (7)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A review of the home's policy for hand hygiene (ICM 07-00-03, reviewed July 2017), revealed all staff will participate in the four (4) moments of hand hygiene. The policy further identified that hand hygiene will be practiced before administering a medication by any route; between tasks and procedures on the same resident; after contact with body substances or specimens; and before and after each resident contact.

Observations of the noon medication pass on January 25, 2018, by RPN #106 revealed a specific procedure and the administration of a specific medication to resident #012 were performed without hand hygiene before or after resident contact.

An interview with RPN #106 confirmed that hand hygiene was not performed when administering the observed medication during the noon medication pass. An interview with the DOC confirmed staff are to perform hand hygiene when administering medications as indicated by the four moments of hand hygiene and as specified by the policy. [s. 229. (4)]

Issued on this 14 day of February 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JUDITH HART (513) - (A1)

Inspection No. / No de l'inspection : 2018_634513_0001 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 027452-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 14, 2018;(A1)

Licensee / Titulaire de permis :
IOOF Seniors Homes Inc.
20 Brooks Street, BARRIE, ON, L4N-5L3

LTC Home / Foyer de SLD :
IOOF Seniors Home
10 Brooks Street, BARRIE, ON, L4N-5L3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Garry Hopkins

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To IOOF Seniors Homes 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 :

LTCHA, 2007, 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).

Order / Ordre :

The Licensee must be compliant with LTCHA, 2007, c. 8, s. 6 (7).
Specifically, the Licensee shall ensure the following:
1. Review with all direct care staff the nature of this incident and the importance of following falls prevention interventions as directed by the plan of care.
2. Review the current falls prevention interventions implemented in the home with all direct care staff.
3. Explore and review case study scenarios focusing on residents who are non-compliant with falls prevention interventions, and present strategies on how staff should manage in these cases.
4. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.
The above mentioned documentation shall be available to the inspector upon request. This order shall be complied no later than May 7, 2018.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

On a specified date in 2017, the home submitted Critical Incident System (CIS) report related to an incident that caused an injury to a resident, for which the resident was taken to hospital and which resulted in a significant change in the resident's

health status. The CIS indicated resident #022 attempted an activity of daily living and had an unwitnessed incident. The resident was transferred to the hospital and was diagnosed with a medical condition.

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that in the above mentioned incident, care had not been provided to resident #022 as specified in the plan as it relates to the staff ensuring that the identified intervention was in place and in working order.

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(653)

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

May 07, 2018(A1)

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:

Health Services Appeal and Review Board and the Director

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

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

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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 14 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JUDITH HART - (A1)

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Service Area Office / Bureau régional de services : Toronto