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

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 public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 26, 2018	2018_638609_0006	034640-16, 012666-17, 014603-17, 014614-17, 015776-17, 024357-17, 025038-17, 029071-17	Critical Incident System

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

CHAD CAMPS (609), LOVIRIZA CALUZA (687)

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): March 21-23, 2018.

This Critical Incident (CI) inspection was associated with:

Two CI reports related to resident abuse;

Three CI reports related to resident falls;

One CI report related to an unexpected death of a resident;

One CI report related to missing narcotics; and

One CI report related to a respiratory outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Director of Food Services (DFS), Nurse Manager, Restorative Care Coordinator, Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Services Aides, Environment Services Aides, residents and family of 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 investigations and reviewed
numerous licensee policies, procedures and programs.**

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident (CI) report was submitted to the Director, which alleged an incident whereby resident #003 demonstrated responsive behaviours towards resident #004.

On a particular day, Inspector #687 observed resident #003 sitting in front of the nursing station and resident #004 was resting in bed.

Inspector #687 reviewed the progress notes of resident #004, which outlined that resident #003 demonstrated responsive behaviours towards resident #004.

In another record review of resident #004’s progress notes, the enacted Substitute Decision-Maker (SDM) of resident #004 was made aware of resident #003’s responsive behaviours and requested that resident #003 and resident #004 have specific interventions in place to protect them both.

In a record review of resident #004’s care plan, Inspector #687 did not identify a focus for the intervention discussed with the enacted SDM.

Inspector #687 conducted an interview with resident #004 about the responsive behaviours of resident #003. Resident #004 could not recall the incident.

In an interview with resident #003, they recalled that the Director of Resident Care (DRC) spoke to them about the incident. Resident #003 denied that the incident occurred.

In an interview with resident #004’s enacted SDM, they stated that they were fully aware of the incident between resident #003 and resident #004. The enacted SDM for resident #004 stated that they had a meeting with the home’s management team and went over all safety measures that had been implemented to keep resident #004 safe.

Inspector #687 conducted an interview with Personal Support Worker (PSW) #112, they indicated that they were not aware of the incident between resident #003 and resident #004. However, the PSW stated that the home implemented interventions for resident #004's safety.

In an interview conducted by Inspector #687 with Registered Practical Nurse (RPN) #125, they stated that they were not aware of the incident between resident #003 and resident #004. The RPN further stated that they were unaware of any interventions in place related to the interactions between resident #003 and #004.

In an interview with the Nurse Manager, they stated that resident #004 and #003 had several behavioural interventions in place to safeguard the residents and acknowledged that these were not transcribed in their care plans.

Inspector #687 conducted an interview with the DRC, they indicated that resident #004's interventions to safeguard the resident were not captured in the care plan of resident

#004. The DRC further stated that their expectation from their staff were to ensure that the care plan set out the care to be provided to the resident and this did not happen for resident #004. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development, implementation and delivery of the care as it related to the residents' care needs.

A CI report was submitted by the home to the Director, which outlined how resident #001 unexpectedly passed away in the home.

a) Inspector #609 reviewed resident #001's health care records and found that when the resident was admitted to the home a clearly defined safety intervention was to have been employed by staff, related to the resident's health condition.

A review of resident #001's plan of care from admission onward, found that the clearly defined intervention was only added weeks after the resident was admitted.

A review of the home's policy titled "Care Planning" effective date April 15, 2016, outlined how staff and others involved in the different aspects of care collaborated in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

During an interview with the staff member #113, they indicated that it was the responsibility of staff member #128 to within 24 hours, develop the plan of care, based on information gathered within the assessment documents.

Staff member #113 acknowledged that a previous staff member #128 did not integrate the nursing admission assessment information into resident #001's plan of care and should have.

b) During an interview with staff member #103, they explained how on a particular day, resident #001 was assessed and based on the outcome of that assessment, the resident required a clearly defined intervention. This was also documented in the resident's assessment. This information was then communicated to staff through an email to staff members #113 and #128, dietary staff, RPNs and RNs to ensure that the plan of care was updated and accurate.

A review of correspondence from staff member #103 found that despite an email to staff members #113 and #128, dietary staff, RPNs and RNs, no update to resident #001’s plan of care occurred until days later when staff member #103 followed up and revised the resident's plan of care with the clearly defined intervention.

A review of the payroll for staff on two particular days, found that staff member #128 was present and working and did not integrate staff member #103's recommendations into the resident's plan of care.

During an interview with staff member #113, they indicated that despite the email from staff member #103, resident #001’s plan of care was not integrated with staff member #103's assessment information and should have been. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the resident’s plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A CI report was submitted by the home to the Director, which outlined how resident #007 fell, was transferred to hospital and diagnosed with an injury.

Inspector #609 reviewed resident #007’s post fall assessment, which described how the resident was found on the floor after self-transferring.

A review of resident #007’s plan of care at the time of the inspection, required that they have four interventions in place to safeguard the resident.

On two particular days, resident #007 was observed without the four interventions outlined in the plan of care in use.

During an interview with PSW #124, they verified that three of the interventions outlined in resident #007's plan of care were outdated.

During an interview with RPN #125 they verified that the four interventions resident #007 was to have in place for safety were outdated and that their plan of care required updating.

A review of the home’s policy titled “Care Planning” effective date April 15, 2016, required the resident’s plan of care be reviewed and revised when the resident’s care

changed or the care set out in the plan was no longer necessary.

During an interview with the Nurse Manager, a review of resident #007's plan of care as well as the inspector's observations were conducted. They verified that the four interventions to safeguard resident #007 were outdated and that the plan of care required updating.

When asked why resident #007's plan of care was not up to date, the Nurse Manager indicated that the resident's care plan should have been up to date, but that it had been a struggle for RPNs to keep up with revisions to resident care plans. The Nurse Manager then indicated that registered staff required additional education as to what information was required in the plan of care, when it was to be updated and that they would update resident #007's plan of care. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 22nd day of May, 2018

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

Original report signed by the inspector.

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) :	CHAD CAMPS (609), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2018_638609_0006
Log No. / No de registre :	034640-16, 012666-17, 014603-17, 014614-17, 015776-17, 024357-17, 025038-17, 029071-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 26, 2018
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

---

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must be compliant with s. 6. (4) of the Long Term Care Homes Act (LTCHA).

The licensee shall prepare, submit and implement a written plan to ensure that the 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 the different aspects of care are integrated and are consistent with and complement each other.

The written plan must include, but is not limited, to the following:

-Identify who is accountable for ensuring that residents' information is immediately integrated into the residents' plans of care.

-Outline the responsibilities of each staff member for ensuring that residents' information is correct, is immediately integrated into the resident's plan of care and is implemented.

-Define how residents' information is immediately communicated to all staff involved in the residents' care delivery.

Please submit the written plan, for inspection #2018-638609-0006 to Chad Camps, LTC Homes Inspector, MOHLTC, by email to SudburySAO.moh@ontario.ca by May 8, 2018.

Please ensure that the submitted written plan does not contain any Personal Information (PI) / Personal Health Information (PHI).

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development, implementation and delivery of the care as it related to the residents' care needs.

A CI report was submitted by the home to the Director, which outlined how resident #001 unexpectedly passed away in the home.

a) Inspector #609 reviewed resident #001's health care records and found that when the resident was admitted to the home a clearly defined safety intervention was to have been employed by staff, related to the resident's health condition.

A review of resident #001's plan of care from admission onward, found that the clearly defined intervention was only added weeks after the resident was admitted.

A review of the home's policy titled "Care Planning" effective date April 15, 2016, outlined how staff and others involved in the different aspects of care collaborated in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

During an interview with the staff member #113, they indicated that it was the responsibility of staff member #128 to within 24 hours, develop the plan of care, based on information gathered within the assessment documents.

Staff member #113 acknowledged that a previous staff member #128 did not integrate the nursing admission assessment information into resident #001's plan of care and should have.

b) During an interview with staff member #103, they explained how on a particular day, resident #001 was assessed and based on the outcome of that assessment, the resident required a clearly defined intervention. This was also documented in the resident's assessment. This information was then communicated to staff through an email to staff members #113 and #128, dietary staff, RPNs and RNs to ensure that the plan of care was updated and accurate.

A review of correspondence from staff member #103 found that despite an email to staff members #113 and #128, dietary staff, RPNs and RNs, no update to resident #001's plan of care occurred until days later when staff member #103 followed up and revised the resident's plan of care with the clearly defined intervention.

A review of the payroll for staff on two particular days, found that staff member #128 was present and working and did not integrate staff member #103's recommendations into the resident's plan of care.

During an interview with staff member #113, they indicated that despite the email from staff member #103, resident #001's plan of care was not integrated

staff member #103's assessment information and should have been.

The severity of this issue was determined to be a level three, as there was actual harm that came to resident #001. The scope of the issue was a level one or isolated to resident #001 whose assessments were not integrated into their care plan. The home had a level two compliance history, as the licensee had unrelated non-compliances with this section of the LTCHA. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 18, 2018

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

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 26th day of April, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Chad Camps

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