Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 2, 2021	2021_824736_0004	022988-20, 023618-20	Critical Incident System

Licensee/Titulaire de permis

IOOF Seniors Homes Inc.
20 Brooks Street Barrie ON L4N 7X2

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

AMANDA BELANGER (736)

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): February 22-25, 2021.

During the course of the inspection, the following intakes were inspected:
-one intake related to a report submitted to the Director for a fall of a resident that resulted in an injury; and,
-one intake related to a report submitted to the Director for a medication error that resulted in a resident transfer to the hospital.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Nurse Manager(s), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Service Assistants (CSAs) Housekeeping staff, and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health records, as well as licensee policies, medication management program, as well as procedures and programs, and internal audits.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs administered to the resident were in accordance with the directions for use specified by the prescriber.

The resident was ordered to have a specific medication administered once daily for five days. The resident had a change in condition and was transferred to the hospital; it was noted that on the day of the hospital transfer and the day prior, the resident did not receive their scheduled doses of the specific medication.

The licensee's internal investigation notes indicated that the medication did not arrive from the pharmacy, and that the Registered Practical Nurse (RPN) signed on the resident's electronic medication administration record (eMAR) to indicate that the medication had been administered, although the medication had not been administered.

Sources: The resident's progress notes, and eMAR; the resident's physician's order sheet; medication incident report; Critical Incident (CI) report; interviews with a RPN, and Associate Director of Resident Care (ADRC), as well as other staff. [s. 131. (2)]

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 medications are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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 participated in the infection prevention and control program (IPAC), specifically related to the hand hygiene program.

During an observation, the Inspector observed a staff member collect dirty items from a resident, place the items in the garbage and then prepare items from the snack cart; no hand hygiene was observed. The Inspector also observed the staff member collect dirty items from various residents, and then continued to assist with the snack cart, without any hand hygiene.

In an interview with the Care Service Assistant (CSA), they indicated that they had missed moments of hand hygiene during the snack cart distribution.

The CSA failed to participate in the implementation of the IPAC program, which presented actual risk of infection to the residents on the home area.

Sources: Inspector observations; interview with the CSA, and other staff; licensee's policy titled: "Hand Hygiene", #ICM 07-00-03, last reviewed August 2020. [s. 229. (4)]

Issued on this 3rd day of March, 2021

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

Original report signed by the inspector.