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

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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
Sep 10, 2021	2021_745690_0018	008278-21, 008418-21	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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 23-27, 2021

The following intakes were inspected upon during this Critical Incident System inspection:

-One log, which was related to a critical incident that the home submitted to the Director related to an allegation of staff to resident abuse and,
-One log, which was related to a critical incident that the home submitted to the Director related to a missing resident.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Assistant Director of Care (ADOC), Manager of Environmental Services, Infection Prevention and Control Lead, Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home were kept closed and locked.

A review of a resident health records described an incident that occurred in which a resident was found outside the home.

In separate interviews with the Assistant Director of Care (ADOC), and the Manager of Environmental Services, they indicated that the resident was able to exit from the home either because a door did not latch properly or the resident followed a staff member out. The ADOC informed the inspector that during the investigation into the incident it was discovered that a door to the outside had been propped open and was not alarmed. Both the ADOC and Manager of Environmental Services verified that all doors leading to the outside should have been kept closed and locked at all times.

Sources: A Critical Incident System report (CIS), a resident's health records, investigation notes, interviews with the ADOC, Manager of Environmental Services, and the Chief Executive Officer (CEO). [s. 9. (1) 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 doors leading to stairways and to the outside of the home are kept closed and locked, to be implemented voluntarily.

WN #2: 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 has failed to ensure that two residents were protected from abuse by a Personal Support Worker (PSW).

Physical abuse is defined within the Ontario Regulations (O. Reg.) 79/10 of the LTCHA, 2007, as "the use of physical force by anyone other than a resident that causes physical injury or pain". Verbal Abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A review of the home's investigation notes related to an allegation of verbal and physical abuse of two residents, described two incidents that occurred on the same day, in which a PSW had witnessed another PSW verbally and physically abuse two residents.

In an interview with the PSW that reported the alleged abuse, they verified that they had witnessed the physical and verbal abuse of both residents. The PSW, further verified that had they reported the first incident immediately, then the second incident could have been prevented. In interviews with ADOC, they verified that the accused PSW had physically and verbally abused the two residents.

Sources: The home's policy titled "Zero Tolerance for Abuse and Neglect", the home's investigation notes ,a PSW's personnel file, interviews with PSW staff, and the ADOC. [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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

On April 1, 2021, the Assistant Deputy Minister (ADM) informed licensees via a memo related to enhanced cooling requirements to the Ontario Regulations (O. Reg) 79/10 of the Long-Term Care Homes Act (LTCHA), 2007. The memo highlighted a summary of the recent amendments to the regulations and that the changes would come into effect on May 15, 2021.

A review of the "Air Temperature Audit" Sheets, identified that there were no temperature checks recorded after 5:00 p.m. on two separate dates, in any area of the home.

In interviews with the Manager of Environmental Services and the CEO, they verified that they were aware of the changes related to temperature checks and that there was to be temperature checks every day after 1700 hours. The Manager of Environmental Services stated that if there were missing temperatures on the audit logs for those two days after 1700 hours, that it had been missed and not completed.

Sources: The home’s policy titled “Heat Related Illness and Management Program”, the home’s Air Temperature Audit Sheets, interviews with the Manager of Environmental

Services, and the CEO. [s. 21. (2) 1.]

2. A review of the home's "Air Temperature Audit" Sheets, for a two month period, identified that there were temperature checks being done for two resident rooms in different parts of the home and three common areas, three times daily.

During a interview with the Manager of Environmental Services, they agreed with the inspector that according to the lay out of the home, there were four different floors in the home, and that there should be a temperature check being completed in two resident bedrooms in different parts of the home and a common area on all four floors. In an interview with the CEO, they indicated that the home had misunderstood the legislation and had been doing one temperature three times a day on every unit, which included the resident rooms and common areas. The CEO further verified that they should have been doing a temperature check in a common area on all four floors and two resident bedrooms three times a day.

Sources: Memo from the ADM, related to enhanced cooling requirements, dated April 1, 2021, the home's "Air Temperature Audit" Sheets, interviews with the Manager of Environmental Services, and the CEO. [s. 21. (2) 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 air temperatures are measured and documented in writing in two resident bedrooms in different parts of the home, and one common area on every floor, three times a day, to be implemented voluntarily.

WN #4: 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 anyone who had reasonable grounds to suspect abuse by a staff member that resulted in risk of harm to two residents, immediately reported the suspicion to the Director. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

A review of the home's policy titled "Mandatory Reporting and Whistle Blowing Protection", stated that any staff who was aware of or suspected abuse of a resident by anyone must immediately report the incident to the immediate supervisor or manager/department head, and that the home was to immediately report the allegation to the Director.

A review of investigation notes identified that a PSW had witnessed two incidents several hours apart on the same day in which another PSW verbally and physically abused two residents . Neither incident was reported by the PSW immediately. A review of the after hours report submitted by the home, identified that the incidents were not reported to the Director until several hours later.

The PSW that reported the allegations, stated that they did not immediately report the two incidents and that they should have. In an interview with a Registered Nurse (RN), and the ADOC, they both identified that any incident of alleged, suspected or actual abuse of a resident was to be immediately reported to the Registered Practical Nurse (RPN), RN, or a Manager, and that the incident would be reported immediately to the Director.

Sources: The home's policy titled "Mandatory Reporting and Whistle Blowing Protection", the Ministry of Long Term Care after hours report, the home's investigation notes, interviews the ADOC, and other staff. [s. 24. (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 anyone who had reasonable grounds to suspect abuse by a staff member that resulted in harm or risk of harm to a resident, immediately reported the suspicion to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of the witnessed incidents of physical abuse of two residents by a PSW.

During a review of the investigation notes, and health records for the two residents, the Inspector could not find any information related to notifying the police of the allegations of physical abuse.

A review of the home's policy titled "Zero Tolerance for Abuse and Neglect", stated that every licensee of a long-term care home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

In interviews with the ADOC, and the CEO, they verified that the police were not notified of the incidents of physical abuse of the two residents. The CEO verified that the police should have been notified of both allegations of abuse.

Sources: The home's policy titled "Zero Tolerance for Abuse and Neglect", the home's investigation notes, interviews with staff, the ADOC, and the CEO. [s. 98.]

Issued on this 14th day of September, 2021

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

Original report signed by the inspector.