Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
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Original Public Report

Report Issue Date: October 21, 2022	
Inspection Number: 2022-1492-0001	
Inspection Type: Critical Incident System	
Licensee: IOOF Seniors Homes Inc.	
Long Term Care Home and City: IOOF Seniors Home, Barrie	
Lead Inspector Shannon Russell (692)	**Inspector Digital Signature** Shannon K Russell Digitally signed by Shannon K Russell Date: 2022.10.26 15:42:03 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 3-5, 2022.

The following intake(s) were inspected:

- Intake: Related to an Incident involving a resident resulting in a significant change in status.

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Responsive Behaviours
Infection Prevention and Control

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Responsive Behaviours

NC #01 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22 s. 58 (4) (b)

The licensee shall:

1. Complete a documented review of the resident's interventions to manage exhibited responsive behaviours and the effectiveness of the intervention.
2. Develop and implement an auditing process to ensure that the interventions are implemented as per the resident's plan of care. Documentation of the auditing process must be maintained, and the audits must continue for at least one month post the compliance due date to ensure sustainability.
3. Implement and evaluate any corrective actions required to address any identified deficiencies during the audits while ensuring that corrections are incorporated into the quality improvement processes of the home and that these improvements are documented.

Grounds
The licensee has failed to ensure that strategies were developed and implemented to meet the needs of a resident in response to their demonstrated responsive behaviours.

There had been an incident involving a resident, which resulted in significant injuries, and a significant change in the resident's health status.

At the time of the incident there had been specific strategies that were to be put in place to mitigate the responsive behaviour, due to a previous incident involving the resident; however, the interventions had not been implemented when the incident occurred.

There were multiple progress notes for a four-month period that identified the resident had exhibited the responsive behaviour on a daily basis. The resident's care plan had not been updated with the strategies until after the second incident, which caused a significant change in their health status.

The direct care staff involved in the care of the resident indicated that they had not been aware of what strategies were to be put in place for the resident. The Director of Care (DOC) identified that they had failed to update the resident's plan of care with the strategies to mitigate the resident's exhibited responsive behaviours until after the second incident where the resident sustained significant injuries; therefore, they had not been implemented, and they should have been.

There was a high impact to the resident due to them sustaining significant injuries and a high risk at the time of the incident as the strategies had not been implemented.

Sources: Critical Incident System (CIS) report; a resident's health care records, including progress notes, assessments and care plan; the home's internal investigation notes; the home's policy, titled "Security Door checks", #05-00-65, last revised July 2021; and interviews with direct care staff, the Director of Facilities and Environmental Services, an Assistant Director of Care (ADOC), and the DOC. [692]

This order must be complied with by November 25, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.