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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 2, 2024
Inspection Number: 2024-1492-0001
Inspection Type: Critical Incident
Licensee: IOOF Seniors Homes Inc.
Long Term Care Home and City: IOOF Seniors Home, Barrie

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.02.02 12:18:42 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 24 and 29 - 31, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
- Intake: #00098020-23 - related to fall prevention
- Intake: #00101199-23 – related to COVID-19 Outbreak and infection prevention and control practices
- Intake: #00106722-24 – related to an improper transfer of a resident

The following intake was completed in this inspection:
-Intake #0094281 were related to falls prevention.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that a resident had fall prevention interventions in place as specified in their plan of care.

Rationale and Summary
A resident was at risk for falls. Their care plan stated they required specific fall preventions interventions to be in place.

The resident fell when getting out of bed. The registered staff completed an assessment and noted that the resident did not have all their fall prevention interventions in place at the time of the fall.

The resident was negatively impacted when they were not provided their required

fall prevention interventions as per their plan of care, and had a fall that resulted in an injury that required treatment at the hospital.

Sources: Review of the residents' plan of care, progress notes, interview with a Personal Support Worker (PSW) and an Registered Practical Nurse (RPN).
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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident was being assisted by a PSW to sit down when their equipment slid out from behind the resident, and they fell to the floor.

The PSW acknowledged they did not put the brakes on the equipment before the transfer.

The resident was negatively affected by the fall, complained of pain and was sent to the hospital for an assessment.

Sources: review of a residents' progress notes, the home's investigation notes, interview with a PSW and RPN.
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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that when a resident developed impaired skin integrity that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A resident developed multiple areas of impaired skin integrity. The registered staff only documented the location of the impairment and did not complete a skin assessment using the home's "skin-new impaired integrity" note.

The home's progress note titled "Skin-New Impaired Integrity" was considered a clinically appropriate assessment instrument that was specifically designed for skin

and wound assessments.

The Assistant Director of Care (ADOC) who was the home's skin and wound care lead, stated the assessment should have included the location, measurements, colour, pain and known cause of the impairment and be documented in the progress notes under the new impaired integrity note.

The residents impaired skin integrity was not assessed by a registered staff using a clinically appropriate assessment instrument which may have prevented ongoing accurate monitoring and assessment of the impairment when the initial assessment was not documented appropriately.

Sources: review of residents' head to toe assessment, progress notes, interview with an RPN and the ADOC.
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WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident with impaired skin integrity was reassessed at least weekly by a member of the registered nursing staff if clinically

indicated.

Rationale and Summary
A resident required additional clinical monitoring related to a medication they were receiving. The resident developed adverse effects of the medication a few days after impaired skin integrity had developed on multiple areas on their body.

A weekly skin assessment was not completed for their impaired skin integrity.

The home's skin and wound care lead stated that re-evaluation of the residents' impaired skin integrity should have been done at least weekly using the home's progress note titled "Skin wound weekly assessment".

Sources: review of the residents' progress notes, and assessments, interview with an RPN and the ADOC.
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WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to ensure that the equipment shared between residents was cleaned or disinfected with a low-level disinfectant in accordance with evidence-based practices and if there were none, in accordance with prevailing practices.

Rationale and Summary
A PSW and a PSW student used a piece of equipment that was shared between two residents. The equipment was not cleaned between the two residents nor before being used with a third resident.

A PSW stated that it was the night shift PSW's that were responsible for disinfecting the equipment and it was not disinfected between residents.

The home's IPAC lead stated that all resident equipment was to be disinfected between use.

Sources: Observations during the inspection, Interview with a PSW and IPAC Lead, Policy #ICM-07-00-01 Routine Practices, review date: May 2023.
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WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under

subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to inform the Director immediately in as much detail as possible in the circumstances of a COVID-19 outbreak being declared in the home.

Rationale and Summary
Public Health declared a COVID-19 outbreak at the home. The home submitted a critical incident report to the Ministry of Long-Term Care (MLTC) two days later.

The Director of Care (DOC) stated that the outbreak was not reported immediately, and it should have been reported to the MLTC via the after-hours line when the outbreak was declared.

Sources: review of the critical incident report, Interview with DOC.
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