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
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Original Public Report

Report Issue Date: June 13, 2024

Inspection Number: 2024-1492-0003

Inspection Type:
Complaint
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: 2024.06.18 12:58:00 -04'00'

Additional Inspector(s)
Daniela Lupu (758)
Amanpreet Kaur Malhi (741128)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
May 14-17, 23, 24, and 27-30, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
- Intake #00112380 - related to Infection Prevention and Control, and outbreak measures.
- Intake #00112556 – related to an allegation of resident abuse.
- Intake #00114590 – related to fall prevention and management.

The following intake(s) were inspected in this Complaint inspection:
- Intake #00113649 - related to an allegation of resident abuse and concerns

related to resident's rights.
- Intake #00114482 – related to fall prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO BE TREATED WITH RESPECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth and individuality.

Rationale and Summary
A resident requested that staff call them by their pseudonym name, which was reflected in their plan of care. Staff did not abide by the resident's wishes and instead called them names associated with terms of endearment.

When staff did to not call them by their pseudonym name, they felt disrespected, angry, and as though they were not a human being.

Sources: resident's care plan, interview with Registered Practical Nurse (RPN), Assistant Director of Care (ADOC) and Director of Care (DOC).
[729]

WRITTEN NOTIFICATION: RIGHT TO AN OPTIMAL QUALITY OF LIFE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 6.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The licensee failed to ensure that a residents' right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference was respected.

Rationale and Summary
A resident planned a leave of absence from the home and provided the home with notice of their intentions.

The following day after the resident left the home, the home's management staff went to the resident's location unannounced to complete a wellness check.

The resident felt that their right to privacy was not respected while they were away from the home and that staff did not communicate any safety or wellness concerns prior to them leaving the home.

Sources: Review progress notes, MDS outcome summary score, interview with the resident, and ADOC.
[729]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee failed to ensure that a resident's right to give or refuse consent to the administration of medications, and to be informed of the consequences of giving or refusing consent was respected.

Rationale and Summary

A resident had new medications prescribed with an indication that when or if they refused, their medication could be mixed with meals, drinks, or snacks.

The resident was not informed of the newly prescribed medications and staff did not offer the medications, instead mixed the medications in their drinks.

The resident was made aware that staff were administering their medication in their drinks three days after they were prescribed. As a result of the medications being mixed in their drink, the resident refused to consume any drinks that was prepared by the home.

By not promoting or protecting the resident's right to give or refuse consent in relation to medication administration, the resident no longer trusted staff to not hide medication in their drinks.

Sources: review of progress notes, psychogeriatric referral and consult notes, physician digiorder, email communication from ADOC to physician and electronic medical record (eMAR). Interview with ADOC, and RPN.
[729]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee failed to ensure that the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care were documented in relation to fall prevention for a resident.

Summary and Rationale

A resident fell from their bed and sustained an injury requiring a transfer to the hospital for assessment and treatment.

The resident did not have fall prevention interventions documented in their plan of care prior to the fall.

After the resident's fall, the home implemented additional fall prevention interventions; however, the interventions, outcomes or effectiveness of the interventions were not documented in their plan of care. This lack of documentation put the resident at ongoing risk for additional falls when staff may not be aware of their fall prevention interventions.

Sources: Review of a residents' care plan, care plan revision history, progress notes, post fall assessments, resident feedback form. Observations of the resident, interview with Personal Support Worker (PSW), Registered Nurse (RN) and ADOC. [729]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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:

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.

The licensee has failed to ensure that when there were reasonable grounds to suspect that abuse had occurred, that they immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

An allegation of physical abuse towards a resident was identified and was not reported to the Director until four days after the incident occurred.

By not immediately reporting the suspicion of alleged abuse, the Director was unable to respond immediately.

Sources: Critical Incident (CI) #, Resident # 002 and #003's clinical records and Interviews with the home's staff.

[741128]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 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 safe positioning devices and techniques were used by staff when repositioning a resident.

Rationale and Summary

A resident required the assistance of two staff members for all personal care, transferring, and repositioning and required the use of positioning aides in bed.

A PSW was providing care to the resident when they left the resident unattended to obtain additional supplies. The PSW did not ensure that the positioning aides were in place when they left the resident unattended and when they returned, the resident had rolled from the bed to the floor and suffered an injury.

The resident was negatively impacted when staff did not provide the care or repositioning with two staff members that was required and furthermore, the resident was left unattended without their positioning aides in place to ensure their safety.

[729]

WRITTEN NOTIFICATION: Required Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

Required programs

s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,

(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee failed to provide for assessment and reassessment instruments in relation to their falls management program.

In accordance with O. Reg. 246/22 s. 11(1)(b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Specifically, staff did not comply with the home's head injury monitoring policy # RCM 12-01-04, dated August 2023, which was included in the home's fall prevention and management program.

Summary and Rationale:

A resident had a fall and suffered an injury that required head injury monitoring. The resident was on medications that required close monitoring when there was an increased risk of bleeding after an injury.

The home initiated their policy to assess and monitor the resident using the electronic 48-hour Head Injury Record 2.0 (HIR). The HIR assessment was not completed at the recommended intervals for twelve hours, sixteen hours, twenty hours or twenty-four hours after their fall.

The ADOC stated the registered staff did not follow the home's HIR policy and the resident was at higher risk of developing complications after the fall related to their medication use.

Sources: Review of resident's progress notes, 48-Hour HIR 2.0 assessment tool, post fall assessment, policy # RCM 12-01-04 dated August 2023, titled Required Programs, section: Fall Prevention and Management. Interview with RN and ADOC. [729]

WRITTEN NOTIFICATION: Skin and wound care

NC #008 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 when a resident exhibited altered 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.

Summary and Rationale
A resident had three identified areas of altered skin integrity that was identified on a head-to-toe assessment.

The staff did not document the resident's new areas of altered skin integrity using the home's wound care application that was considered to be a clinically appropriate assessment instrument.

When the home did not complete initial baseline assessments using a clinically appropriate assessment instrument, the registered nursing staff would not be able to identify if the resident had a deterioration in their impaired skin integrity that may have required additional treatment and intervention.

Sources: Review of a resident's progress notes, skin and wound assessments, electronic treatment administration record (eTAR), electronic medication record (eMAR), interview with RN and Assistant Director of Care (ADOC).
[729]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 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 when a resident had areas of altered skin integrity, that they were reassessed weekly by a member of the registered nursing staff.

Summary and Rationale
A resident had three areas of altered skin integrity. The home did not complete weekly skin and wound assessments after the altered skin integrity was identified.

The RN stated the resident required weekly skin and wound re-evaluations as the resident was at higher risk of complications due to the medications that they were taking.

Sources: Review of a resident's progress notes, skin and wound assessments, electronic treatment administration record (eTAR), electronic medication record (eMAR), interview with RN and ADOC.
[729]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary
A parainfluenza outbreak was declared at the home on a Resident Home Area (RHA). Six residents were on droplet and contact precautions during the outbreak and at the time of the inspection.

Droplet and Contact Precaution signage posted at the entrance to these resident's rooms directed staff and visitors to wear a mask, eye protection, a gown, and gloves when in the residents' rooms or within two meters of the residents.

A) The IPAC Standard for Long-Term Care Homes, revised September 2023, section 6.1 states the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk.

On multiple occasions during the inspection, no eye protection was observed in the PPE caddy at the entrance to the six residents' rooms identified above.

The home's IPAC Lead and an RPN said all PPE supplies, including eye protection, should be available at the point of care when Droplet and Contact Precautions were in place for residents.

Sources: observations of Additional Precautions, PPE availability at the Point of Care, Droplet and Contact Signage, residents' clinical records, IPAC Standard (September 2023), and interviews with RPN and the home's IPAC Lead.

B) The IPAC Standard for Long-Term Care homes, revised September 2023, section 9.1 states the licensee shall ensure that Additional Precautions are followed in the IPAC Program. Specifically, at minimum, routine practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal and point-of-care signage indicating that enhanced IPAC control measures are in place.

Multiple observations during the inspection showed staff not wearing eye protection

or changing their masks when in close contact, and providing direct care to isolated residents.

Contact Precaution signage was posted at the entrance to a resident's room, directing staff to wear gown and gloves. An RPN said this was the incorrect signage and Droplet and Contact Precaution signage should be posted instead. This signage would require staff to wear a gown, gloves, mask, and face shield to prevent the spread of infection.

The home's IPAC Lead said staff were required to follow the directions listed on the Droplet and Contact Precautions signage and when providing care or being within two meters of residents on those precautions. They said staff were also expected to change their mask and disinfect their eye protection when exiting residents' rooms on those precautions.

Sources: observations of Additional Precautions, PPE use and availability at the Point of Care, Droplet and Contact Signage, residents' clinical records, IPAC Standard (September 2023), and interviews with PSW's, RPN and the home's IPAC Lead.

C) The IPAC Standard for Long-Term Care Homes (LTCHs), revised in September 2023, section 4.3 states the licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

A respiratory outbreak was declared by Public Health on a RHA and it was finalized after twenty days.

The IPAC Lead said following the resolution of the outbreak, no debrief was held with OMT and the interdisciplinary IPAC Team to assess IPAC practices that were effective or ineffective in the management of the outbreak. Additionally, no summary of findings or recommendations for improvement to outbreak management practices were identified.

Sources: critical incident report, IPAC Standard (September 2023), the home's outbreak records and an interview with the IPAC Lead.
[758]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The licensee has failed to comply with the reporting protocol based on requirements under the Health Protection and Promotion Act for a suspected respiratory outbreak.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that there is a reporting protocol within their outbreak management system based on the requirements under the Health Protection and Promotion Act and must be

complied with.

Rationale and Summary

The home's policy related to the routine surveillance during non-outbreak times, documented that in the absence of the IPAC Lead, registered nurses should notify Public Health Infectious Disease Program during off hours whenever there were two cases of acute respiratory tract illness within 48 hours on one unit as per case definition. An Outbreak should be suspected, and tests should be done to determine the causative organism. The case definition for upper respiratory illness included cough, nasal congestion, and runny nose.

Within a forty-eight-hour timeframe, four residents presented with acute respiratory symptoms which included new or worsening cough, runny nose and nasal congestion on one RHA.

The Public Health Unit was not notified until the third day of the suspect outbreak when the IPAC Lead was on site. On the fourth day, a respiratory outbreak was declared at the home.

The IPAC Lead said the registered staff should have notified the Public Health unit as required.
Staff not complying with the reporting protocol for suspected outbreaks resulted in a delay of implementing appropriate outbreak interventions.

Sources: the home's outbreak line listing, resident clinical records, the home's policy #ICM-05-00-07, Surveillance and Data Collection - Routine Respiratory Surveillance During Non-Outbreak Times, last revised on January 24, 2024, and an interview with the IPAC Lead. [758]

WRITTEN NOTIFICATION: Medication management system

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to implement IOOF's policy for transcribing physician's medication orders for a resident.

In accordance with O. Reg 246/22 s. 11 (1)(b), the licensee was required to implement written medication management policies in accordance with evidence-based practices and if there was none, in accordance with prevailing practices.

Specifically, staff did not comply with the policy "Transcribing and processing orders" policy #EC-MM-09-13, effective April 2022, which was included in the licensee's Medication Management policy

Rationale and Summary

A resident had medication orders incorrectly transcribed into the physician digiorder form.

The registered staff did not inform the resident of the new medication orders and the second check of the physician's order by a registered staff did not identify the incorrect transcription of the medication order.

The home's policy for medication management titled "transcribing and processing orders" policy #EC-MM-09-13, effective April 2022, stated, the prescribing

practitioner was responsible for obtaining informed consent from the resident or alternate decision maker, staff were to review the order for clarity, transcribe the order to electronic medication administration record (eMAR), inform the resident or alternate decision maker, a second nurse was required to review the order and verify accuracy, and for telephone orders, the prescriber was responsible to countersign the order on their next day in the home.

The resident was negatively impacted when they were not informed that prescribed medication had been ordered, nor what the specific instructions related to medication administration contained. There was ongoing risk to the resident as the two medications were incorrectly transcribed to the eMAR for administration up to and including at the time of the inspection.

Sources: review of a residents' progress notes, eMAR, physician's digiorder form, pyschogeriatric referral and consult notes, email from attending physician, medication management policy titled "transcribing and processing orders" policy #EC-MM-09-13, effective April 2022. Interview with RPN, DOC, and ADOC.
[729]