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

Public Report

Report Issue Date: February 7, 2025

Inspection Number: 2025-1492-0002

Inspection Type:
Complaint
Critical Incident

Licensee: IOOF Seniors Homes Inc.

Long Term Care Home and City: IOOF Seniors Home, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22, 23, 27 - 31, 2025 and February 4 - 7, 2025
The inspection occurred offsite on the following date(s): February 5, 2025

The following intake(s) were inspected:

- Intake: #00136872 related to a medication incident.
- Intake: #00137727 related to a complaint regarding resident care and services.

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

Resident Care and Support Services
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 26.
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:
26. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

The licensee failed to ensure that resident who was dying had the right to have family and friends present 24 hours per day.

A substitute decision maker was not notified of the resident's change in status therefore their right to have family and friends present while dying was not promoted and respected.

Sources: resident clinical records, interview with Director of Resident Care.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's

responses to interventions were documented.

On an identified date, a resident was administered a medication by mouth in error. Assessments, reassessments and interventions were completed for the resident, however they were not documented.

Sources: Resident clinical records, interviews with RN, Nurse Practitioner, Director of Resident Care.

COMPLIANCE ORDER CO #001 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review and evaluate the effectiveness of your current medication incident and reporting policy specifically related to progress notes being used to document all actions related to the resident. This evaluation is to included an audit at minimum of the last five medication incidents related to narcotic/ controlled substances or other high risk medications to determine if the policy was followed including documenting all actions related to the resident. A written record of the audit and evaluation is to be kept available in the home.

2. Develop a case study related to the identified medication incident for the purpose of registered staff to learn from the incident and prevent recurrence. This should include a review of administering the identified medication as well as a review of how the medication incident was managed, including documentation of actions taken related to the resident.
3. All registered staff should participate in the case study. A record should be kept of who facilitated the case study, who participated, the date, and the content of the case study.

Grounds

The licensee failed to ensure that no drug was administered to a resident in the home that was not prescribed for the resident.

Rational and Summary:

On an identified date, a resident was administered a medication by mouth that was not prescribed for them.

The resident required additional monitoring and their conditioned changed.

By administering the resident a medication that was not prescribed for them, may have contributed to their decline in condition.

Sources: Critical Incident Report; Medication Incident Report, Medication Incident and Reporting Policy effective September 2024, resident's clinical records, interviews with Director of Resident Care and Physician.

This order must be complied with by March 31, 2025

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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.