Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2014	2014_168202_0010	T-478-14	Complaint

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street, BARRIE, ON, L4N-5L3

Long-Term Care Home/Foyer de soins de longue durée

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 31, 2014, April 01, 02, 03, 04, 07, 08, 09, 2014.

During the course of the inspection, the inspector(s) spoke with director of resident care (DOC), assistant director of resident care (ADOC), nurse managers (NM), nurse practitioner (NP), registered nursing staff, personal support workers (PSW).

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed the home's policies related abuse and neglect of residents, reviewed staff education records as they pertain to abuse and neglect.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of resident #001's clinical records indicated that the resident has an identified number of substitute decision-makers (SDM) for personal care and all care decisions are to be shared. Registered staff indicated, however, that in the event of injury, medication changes, or change in resident health status they will call or leave a message with SDM #1, as he/she is the main billing contact. Staff indicated that in the event of a change in status, or life threatening illness, they are to follow the direction of the advanced care directives signed by the SDM upon admission. The advanced care directives can be changed at any time, and SDM's are called and given the opportunity to change the level of intervention in the event of a change in health status. The advanced care directive for resident #001, directs staff to provide in-house intervention in the event of any life threatening illness.
An interview with an identified RPN indicated that on an identified date, he/she received four phone calls from SDM#2, with concerns regarding resident #001's health status. The RPN indicated that the first call was received by the day shift RPN at 2:00 pm. The evening RPN overheard the day RPN inform SDM#2 that they both were busy sharing shift report and directed SDM#2 to call later. At approximately 2:30 pm, after shift report, the evening RPN received the second phone call from SDM#2, requesting to ask him/her a few questions about the resident. The RPN told SDM#2 that he/she was busy providing care to another resident and directed SDM#2 to call back later. The RPN indicated that during the conversation, he/she assured SDM#2 that the resident was fine. At approximately 3:30 pm, the RPN received a third phone call from SDM#2, requesting that he/she assess the resident. SDM #2 indicated to the RPN that he/she had spoken to the resident several times this day and that the resident appeared to be very confused and not him/herself. The RPN informed SDM#2 that the resident was fine, he/she had spoken to the resident earlier this day and that he/she witnessed the resident go to the washroom while in the room attending to the resident's roommate. At approximately 4:00 pm, a fourth call was received by the RPN from SDM#2, who expressed worry and concern for the resident's health. The RPN indicated to SDM#2 that she was busy working at the nursing station; however, he/she would send a PSW in to check on the resident. An identified PSW confirmed that upon receiving delegation from the RPN to go and check on the resident, he/she did and the resident appeared to be fine. At 4:50 pm, approximately one half hour after the PSW checked in on the resident, the PSW found

the resident to be in his/her room sitting in a chair unresponsive. The PSW alerted the RPN, who then came to the room to assess the resident. The RPN indicated that because the resident was unresponsive and leaning over in his/her chair, called the RN in charge immediately. The RN indicated that the resident was found to be unresponsive, and with unstable vital signs. The RN directed the RPN to call the family. The RPN indicate that he/she first left a message with SDM#1 and attempted to call SDM#2, however, there was no answer. At approximately 5:10 pm, SDM#1, called the home and spoke directly to the RN. SDM#1 directed the RN to wait until he/she arrived at the home so that he/she could assess the resident to decide if the resident should be sent to hospital for further assessment. Between 5:08 pm and 6:10 pm, SDM#2 called the RPN and directed him/her to call 911 and have the resident sent to hospital immediately. The RPN informed SDM#2, that they would not send the resident to the hospital because they were given an earlier direction from SDM#1, to wait until SDM#1 arrives at the home to he/she make the decision to send the resident to hospital or not. At 6:10 pm, SDM#1 arrived at the home and directed the RN to send the resident to hospital immediately. The resident was admitted to hospital with multiple diagnosis which required treatment and hospitalization.
An interview with the DOC confirmed that all SDM's for resident #001 share equal care decisions with the exception of SDM#1, who had been identified as the billing contact upon resident #001's admission. The DOC confirmed that there is no set process in place that would have assisted staff in implementing care decisions that have been requested of individual SDM's when there are several SDM's of joint decision making capacity. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan.

A review of resident #001's plan of care revealed that the resident has an identified number of substitute decision-makers (SDM) for personal care. Registered staff indicated, however, that in the event of injury, medication changes, or change in resident health status they will call or leave a message with SDM #1, as he/she is the main billing contact. A review of resident 001's clinical records revealed that on an identified date, SDM#1 notified the home to inform that he/she will be away for an identified period of time and directed staff call either SDM#2 or SDM#3 in the event of any health concerns or changes pertaining to resident #001. During the identified period, resident #001 fell while in his/her room. The RN indicated in an interview that the resident was assessed for injury, he/she then left a message with SDM#1 regarding the fall and indicated in the message that the resident was being monitored.

The RN confirmed that he/she did not call any of the other SDM's regarding the resident's fall as directed in the plan of care. [s. 6. (7)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, an identified PSW heard yelling coming from outside the dining room of an identified resident home area. The PSW indicated that upon his/her arrival, resident #001 reported that resident #002 was physically aggressive with him/her and because of the physical aggression received, he/she reciprocated. The PSW reported the incident to an identified RN who then assessed both residents for injury. The RN indicated that resident #002 had a noticeable injury and resident #001 had no injury at the time. The RN reported the altercation between resident #001 and resident #002 to the ADOC, who then further investigated and confirmed the above findings. An interview with an identified RPN indicated that resident #001 was further assessed for injury on the following day, which revealed findings of an injury. The ADOC confirmed in an interview that the allegation of abuse was reported to him/her at the time of incident, however did not notify the Director until the end of day of the following day. [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 a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (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. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of resident #001's clinical records revealed that he/she received a medication that had not been prescribed to him/her on an identified date and time. An interview with an identified RPN indicated that during an identified medication pass, he/she accidentally gave resident #001, a medication that had been prescribed to resident #003. The RPN indicated that he/she alerted the NP of this medication error right away, and resident #001 was assessed accordingly. The NP indicated that resident #001 received no ill effects from the medication error.[s. 131. (1)]

Issued on this 15th day of April, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Valerie Johnston.