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

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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
Nov 10, 2014	2014_168202_0022	T-08-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive, BARRIE, ON, L4M-0C4

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

VALERIE JOHNSTON (202), JOANNE ZAHUR (589), JOELLE TAILLEFER (211), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 07, 08, 09, 10, 14, 15, 16, 17, 20, 21, 2014.

During the course of this inspection the following complaint inspection was completed: T-486-14 and the following critical incident inspections were completed: T-690-13 and T-78-13.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), manager of classic care pharmacy, dietitian, nutritional manager, resident care manager (RCM), environmental services manager (ESM), social services manager (SSM), program coordinator, registered nursing staff, personal support workers (PSW), dietary aide, residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, conducted a tour of the home, observed lunch meal services, reviewed staff education records, reviewed the home's policies related to responsive behaviours, resident abuse, medication incidents and infection prevention and control.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear direction to staff and others who provide direct care to the resident.

Health record review of the written plan of care for resident #07 revealed that pain was not an addressed focus and therefore did not identify interventions, both pharmacological and non-pharmacological. Staff interviews indicated that when resident #07 experiences pain, they provide the resident routine narcotics as prescribed and other the use of a Magic bag, warmed blankets, repositioning, rest and relaxation exercises.

Interviews with identified registered staff and the DOC confirmed that pain was not addressed in the written plan of care and therefore did not provide clear direction in the use of pharmacological and non-pharmacological interventions. [s. 6. (1) (c)]

2. Record review for resident #003 indicated that he/she has longstanding pain. The resident has been receiving prescribed scheduled analgesics and has been using a wheelchair to mobilize.

On an identified date, the physician progress notes directed staff to use a trial intervention for resident #003's to provide psychological and physiologic support.

Interviews with the physiotherapist and registered staff confirm that the trial intervention was not identified on the plan of care. The registered staff and charge nurse stated the application of the intervention was verbally communicated by the day charge nurse to the next shift only if the intervention was accepted to be worn by resident #003.

The director of nursing and personal care confirmed that the directions to staff regarding the trial was not included in the written plan of care. [s. 6. (1) (c)]

3. Interview with resident #005, revealed that some staff during the night provide him/her care without waking and letting him/her know that they will be providing care.

Interview with identified staff revealed that the resident needs to be woken up gently and communicated using sign language by touching his/her hand, which would indicate that he required care.

Record review of the written plan of care, did not indicate how to approach and communicate with the resident when he/she required care. Interview with identified staff and the DOC confirmed that the written plan of care does not set out clear direction to staff and others on how to provide direct care to the resident. [s. 6. (1) (c)]

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 the written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the 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 the policy is complied with.

Record review of the home's policy titled, Reporting Medication Incidents revised October 2010, indicated that each medication incident is investigated and reported to the DOC or designate, Medical Director, prescriber, the resident's attending physician or RN (EC) attending the resident.

Record review of the medication administration record for resident #33 directs registered staff to administer an analgesic.

Record review and interview with a registered staff revealed that the analgesic was removed in an identified amount and on an identified date. Record review and interview with registered staff indicated that a new analgesic was applied on an identified date without informing the physician.

Interview with the DOC confirmed that the registered staff should have called the physician before administering a new analgesic. [s. 8. (1) (b)]

WN #3: 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 has failed to ensure that a person who has reasonable grounds to suspect that an unlawful conduct that resulted in harm or a risk of harm to a resident has occurred, shall be reported immediately to the Director.

Record reviews of the progress notes and the home investigation on identified dates, did not indicate that the home had immediately informed the Director when they had reasonable ground to suspect an unlawful conduct from a registered staff toward resident #33.

Interview with the DOC confirmed that he/she did not report immediately to the Director when he/she had reasonable grounds to suspect that the resident's prescribed analgesic was removed by a staff in an unlawful conduct. [s. 24. (1)]

2. Interview with resident #33 revealed that he/she felt assaulted and abused when resident #34 kissed him/her on an identified date.

Interview with the DOC confirmed that the record review did not indicate that the home had immediately informed the Director when there were reasonable grounds to suspect abuse from resident #34 toward resident #33. [s. 24. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle is reviewed by the Residents' Council.

Interviews with the president of Residents' Council and the NM indicated that the menu cycle had not been reviewed by the Residents' Council. [s. 71. (1) (f)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Interviews with the president of Residents' Council and the NM indicated that the meal and snack times had not been reviewed by the Residents' Council. [s. 73. (1) 2.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received annual retraining to the following areas mentioned below:
• The Residents' Bill of Rights,
• The home's policy to promote zero tolerance of abuse and neglect of residents,
• The duty to make mandatory reports under section 24,
• The whistle-blowing protections.
Record review and interview with staff confirmed that 65% of all staff did not receive retraining relating to the Residents' Bill of Rights in 2013. She also confirmed that 47% of all staff did not receive retraining of the home's policy to promote zero tolerance of abuse and neglect of resident, the duty to make mandatory reports under section 24 and the whistle-blowing protections in 2013. [s. 76. (4)]

2. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, received training in behavioural management, at times or at intervals provided for in the regulation.

Record review and interview with staff confirmed that 56% of all staff who provide direct care to residents, as a condition of continuing to have contact with residents, did not receive training in behavioural management in 2013. [s. 76. (7) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged and suspected incident of abuse or a resident that the licensee suspects may constitute a criminal offence.

Record review indicated that an incident occurred on an identified date, constituted an assault and abuse by resident #33 and that the appropriate police force had been notified four days later.

Interview with the DOC confirmed that the only information available was the critical incident report that indicated the police force was called on an identified date and was not called immediately because the licensee wanted to know if the family decided to press charge. [s. 98.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On October 9, 2014, the inspector found six cans of beer in the medication fridge. Interview with the identified registered staff indicated that the cans of beer are kept in the medication fridge to keep the fridge's temperature regulated. The cans of beer are owned by a resident. Record review of the Vaccine Cold Chain Maintenance Inspection Report from the Public Health Protection and Prevention Branch from the last inspection dated July 7, 2014, indicated that only vaccine (no food, beverages and/or medical/laboratory specimens) are stored in the refrigerator. Interview with the ADOC and DOC confirmed that drugs stored in a medication cart should be used exclusively for drugs and drugs-related supplies.

On October 9, 2014, the inspector found one can of coke in the second medication fridge in the same place with the insulin cartridge. Interview with the registered staff revealed that the coke is owned by a resident in home. Observation and interview with the DOC revealed that the can of coke was removed from the medication fridge. Interview with the DOC confirmed that both medication fridges should be used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain. Review of education attendance records for 2013, revealed that 50% of registered staff and 42% of direct care staff did not receive education on pain management.

An interview with the DOC confirmed that not all direct care staff received training in pain management. [s. 221. (1) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation includes the following:
-the names of the persons who participated
-a summary of the changes made, and
-the date those changes were implemented.
A record review of the Infection Control and Prevention meeting minutes and an interview with the home's Infection Control Lead confirmed that there is no written record of an annual evaluation of the Infection Control and Prevention program which included the above mentioned criteria. [s. 229. (2) (e)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a record is kept for each staff member of the home that includes the result of the staff's member's criminal reference check under subsection 75 (2) of the Act.

Interview with the DOC confirmed that the result of an identified registered staff's criminal reference check could not be found in the staff's records. [s. 234. (1) 3.]

Issued on this 10th day of November, 2014

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