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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2017	2017_491647_0007	017179-16, 019090-16, 020457-16	Complaint

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

JENNIFER BROWN (647), CECILIA FULTON (618)

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): April 3, 4, 5, 6, 7, 10, 11, 12, 2017

The following complaints were inspected:
017179-16
019090-16
020457-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental and Nutrition Services Manager, Environmental Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides, Physician Assistant, Residents, Family Members, Substitute Decision Makers, and former employees.

During the course of the inspection, the inspectors conducted observations in the home and resident home areas, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee fully respected and promoted the resident's right to give or refuse consent to any treatment, care or services for which consent is required by law and informed the resident of the consequences of giving or refusing consent.

Review of an identified intake revealed that an identified resident's family member complained that the physician had made a medication change and did not inform or get the consent of the resident or his/her Substitute Decision Maker (SDM) when making this medication change.

Record review revealed that on an identified date, an identified resident's medication had been discontinued during a quarterly medication review.

Review of the resident's progress notes revealed that on an identified date, the resident's family members spoke to the registered staff and raised a concern that the resident's medication had been stopped. The family member felt that the discontinuation of this medication had caused the resident to experience serious medical symptoms.

A progress note on an identified date, revealed that the resident had been very upset that he/she had not been notified about the discontinuation of this medication. The resident was not available for interview during this inspection.

Interview with the physician assistant revealed that they had made the medication change on the recommendation from the pharmacy review. The physicians assistant further revealed that they could not confirm if they had a conversation directly with this resident regarding this particular medication change and the identified resident was very involved in decisions regarding his/her care and directing their own care.

The physician assistant revealed that the family of the identified resident would be aware of the resident's care decisions and that they supported the resident and went along with the decisions he/she made about his/her own care.

Interviews with registered staff members revealed that when they are processing medication changes, it is the role of the registered staff to contact the SDM to inform them about the medication change and if the SDM has concerns or questions about the proposed changes they communicate this to the physician via the home page and the physician would follow up with the concerned party.

Review of the quarterly medication review document revealed that the first and second nurse's signatures were on the document as required.

Interview with a registered staff member confirmed that he/she was the first nurse signatory to this document and that his/her role in processing the order would have included faxing the order to the pharmacy and notifying the SDM regarding this medication change. The registered staff member revealed that he/she could not recall if they had notified the family and that there was no documentation to capture whether they had notified the family. The registered staff member confirmed that this communication with the family would have been captured in the progress notes.

Interview with DOC revealed that the registered staff member had been interviewed at the time of the incident and at that time confirmed that they had not informed anyone about the medication change.

Interview with the DOC confirmed that neither the resident nor his/her SDM had been informed about this medication change and had not been given the right to give or refuse

consent to this change of medication. [s. 3. (1) 11. ii.]

WN #2: 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 plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of an identified intake revealed that an identified resident attends off site activities.

The complainant stated that on an identified date, the resident returned from his/her activity and was not returned to his/her home area as was the usual practice. The complainant further identified that as a result of this, the identified resident was not provided lunch or scheduled care as per his/her plan of care.

Interview and observation of the resident identified that the resident attends off-site activities and that he/she generally returns to the home in the afternoon.

Review of the resident's care plan did not provide any indication of the days when the resident is off-site and had not identified any change to his/her schedule, particularly his/her plan of care for an identified care area that may be affected by the residents absence from the home during these time periods.

Review of resident's plan of care with a registered staff member confirmed that the plan of care did not identify the adjustments in the resident's schedule which would occur as a result of his/her scheduled off site activities and that three focuses in the care plan relating to an identified care area were not consistent and are confusing to staff.

Review of the resident's plan of care with the DOC confirmed that these off-site activities and their effect on the resident's schedules had not been captured in the plan of care and that they should be documented there.

The DOC confirmed that the plan of care for this resident failed to provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint,
(b) the date the complaint was received,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, (d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Review of an identified intake stated that there was a lack of action taken with regards to a complaint that was brought forward by the family of an identified resident regarding the care of the resident.

Record review revealed that on an identified date, the physician ordered a discontinuation of one of the identified resident's medications.

Interviews and record review confirmed that this change was implemented as ordered and that neither the family nor the resident was informed about this change in medication.

Record review revealed that on an identified date, the resident's SDM had a conversation with the Assistant Director of Care (ADOC) in which they made a complaint that they had not been notified of this medication change.

Interview with the DOC revealed that the complaint process as identified in the legislation had not been implemented or followed with regards to processing this complaint. The DOC stated that it was the homes practice to deal with verbal complaints face to face and that the process was not necessarily captured in any documentation that was available for review.

Review of an identified intake stated that an identified resident had been taken to an activity instead of being taken back to the resident home area as expected. As a result of this the complainant stated that resident did not receive lunch or care as required that day.

Interview with the complainant revealed that they were very upset when they discovered this and brought their concerns directly to the administration of the home.

Record review could not identify any documentation of this event, either in the progress notes or in the complaints binder and the complainant was not able to identify the date of the incident.

Interview with the DOC revealed that they were aware of the situation, and that the complainant had come to them to tell them about what had happened, however they had not identified the discussion they had with the complainant at the time of this incident as a complaint and as a result of not identifying that a complaint had been made, they did not follow any complaint process to investigate or respond to this complaint. [s. 101. (2)]

Issued on this 3rd day of May, 2017

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

Original report signed by the inspector.