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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 5, 2017	2017_653648_0004	006941-16, 014481-16, 023099-16, 026884-16, 027309-16, 031726-16, 004526-17, 005987-17	Critical Incident System

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

JOVAIRIA AWAN (648), CECILIA FULTON (618), JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 27, 28, 29, 30, 21, April 3, 4, 5, 6, 7, 10, 11, and 12, 2017.

The following intakes were inspected:
Log# 006941-16
Log# 014481-16
Log# 023099-16
Log# 026884-16
Log# 027309-16
Log# 031726-16
Log# 004526-17
Log# 005987-17

A Written Notification (WN #002), and Compliance Order #002 under O. Reg.79/10, s. 19 (1), identified in this inspection (Log#023099-16) will be issued under a Follow Up Inspection #2017_491647_0006 Log #002834-17 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Environmental and Nutrition Services Manager (ESNM), Environmental Coordinator (EC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides (HA), and Residents.

During the course of this inspection, inspector(s) reviewed resident clinical records, the homes policies, staff schedules and badge report records, and made observations of the homes facilities, staff, and residents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 VPC(s)**
- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The home submitted critical incident system (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) reporting resident #001 had exited from the home on an identified date. The CI report identified resident #001 had been away from the home for some time and was escorted back to the home by PSW #105.

A review of resident #001's progress notes and written plan of care identified the resident to have exhibited an identified responsive behaviour and had previously exited the home.

Observations conducted with RPN #109, the ESNM and DOC identified the doors leading from two identified areas of the home lead to identified individual secure areas. Each identified area was further identified as having a maglocked door leading off the premises.

Interview with PSW #105 revealed he/she found resident #001 off the premises of the home after completing his/her shift on the date of the incident. PSW #105 escorted resident #001 back to the home and reported he/she found an identified door leading off the premises from another identified area open. PSW #105 stated he/she identified the unlocked door in the identified area to management, and demonstrated it was not locking when closed and that it could be pushed open. Upon further inquiry, PSW #105 reported the doors which resident #001 passed through, leading from the home to an identified area were unlocked during an identified season. PSW #105 was unaware if the door through which the resident had exited had been checked prior to the incident by any other staff in the home.

Interviews with RPN #103 and #109 revealed the doors leading to the identified area were open during identified months to residents allowing them to access the doors in the identified area. RPN #109 reported staff were not provided direction to check if the doors in the identified area leading off the premises were locked when the doors to the identified areas were unlocked for residents.

Interview with the EC revealed the doors leading out of the identified area and all doors in the home were fitted with maglocks. The EC was unable to demonstrate if the maglocks on the doors in the identified area had been routinely checked to ensure they were locked when the residents had access to the identified area.

Interview with the ENSM reported the nursing staff were expected to conduct routine checks of the homes internal doors. The ENSM was unable to demonstrate how and how often the doors leading out of the homes identified area were checked to ensure they were locked when the residents had access to the identified area. Interview with the former ESM revealed the home unlocked the doors leading into the area from the home during identified months for the residents to access the identified area. The ESM reported that the home did not conduct routine audits or preventative maintenance on the doors leading outside of the identified area to ensure the maglocks were functional when

residents had access to the identified area.

Interview with the DOC acknowledged the door through which resident #001 had exited from had malfunctioned and was not locked at the time of the incident. Interview with the homes administrator revealed staff would not be aware if the doors leading outside of the identified area were locked unless they were to manually check them. The administrator identified the doors were to be checked by the EC but was unable to demonstrate the frequency of these checks, and unable to demonstrate how nursing staff would ensure the identified area was secure when the residents had access during the identified time period through unlocked doors leading from the home to the identified area.

The home failed the ensure the home was a safe and secure environmental for resident #001.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk. The scope of the non-compliance is isolated. A review of the compliance history revealed that there had been previously issued non compliance to O. Reg. 79/10, s. 5 to the licensee during inspection #2015_369153_0002 of April 24, 2015

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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).

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 has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

Review of an identified intake revealed that resident #026 had not been provided an identified care measure upon returning to the home.

Interview and observation of the resident identified that the resident will attend outings at an identified time of day and that he/she generally returns at an identified time.

Review of resident #026's written plan of care did not provide any indication of when the resident is away from the home and not identify any change to his/her schedules, particularly his/her plan of care for the identified care measure that may be affected by the residents absence from the home during these time periods.

Review of the resident's written plan of care with Registered staff #109 confirmed that the care plan may be confusing to people.

Review of the resident's written plan of care with the DOC confirmed outings and the effect on the resident's schedules had not been captured in the written 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)]

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

The home submitted a CIS report to the MOHLTC on an identified date, indicating that an incident occurred that had caused injury to a resident that resulted in the resident being transferred to the hospital. A review of the above mentioned CIS indicated that during a transfer of resident #017 using a sit to stand mechanical lift, the health changed. Resident #017 was transferred to the hospital on an identified date and was diagnosed with an identified injury. Resident #017 received the appropriate care in hospital and returned to the home.

A review of resident #017's plan of care identified the resident as dependent and

required the use of a sit to stand mechanical lift with two staff for all transfers.

A record review of the above mentioned incident indicated that resident #017 had only been transferred with one staff member present.

Interviews with RPN's #100, #109, and PSW #101 indicated that on the date of the incident, resident #017 had been transferred via a sit to stand lift with one staff member who had been an agency employee to assist. The above mentioned staff further indicated during an interview that the agency employee did not provide a safe transfer as resident #017 had been transferred by himself/herself and not with two staff members as the plan of care indicated.

An interview with the DOC confirmed that all interventions in the plan of care for resident #017 are expected to be followed. The DOC further confirmed that when resident #017 had been transferred by one staff using the mechanical sit to stand lift the staff member did not provide the care to resident #017 as specified in the plan of care. [s. 6. (7)]

3. The home submitted a CIS report to the MOHLTC reporting resident #001 had exited from the home on an identified date. The CI report identified resident #001 had been away from the home for some time and was escorted back to the home by PSW #105.

Record review of resident #001's clinical records identified progress notes indicating the resident had exhibited an identified responsive behaviour on an identified number of occasions.

A progress note identified that resident #001 had left the grounds through an identified door. He/she was found by staff in an identified area attempting to leave the home. An identified safety intervention was instituted for resident #001 on an identified date following this incident.

The home submitted another CIS on a later date to the MOHTLC reporting resident #001 had exited from the home through an identified exit from an identified area on an identified date. The CI report identified resident #001's whereabouts were unknown to staff for an identified period of time

Review of resident #001's written plan of care at the time of the incident, identified the resident with an identified responsive behaviour. The interventions to manage the an identified responsive behaviour directed staff to an identified measure to ensure that

resident #001 was safe.

Review of resident #001's clinical records identified a flow sheet for which staff were to enter the safety measure. The flow sheet did not identify documentation of entries for the identified safety measure on the date of the incident for an identified time frame for resident #001.

Interview with PSW #105 revealed he/she had found resident #001 in an identified area away from the home. PSW #105 reported he/she escorted the resident back the home upon realizing he/she had exited.

Interview with PSW #102 revealed he/she was on duty during the an identified shift and was assigned resident #001's home area on the day of the incident. PSW #102 reported that an identified safety measure was to be completed for residents at the start of shift and throughout by monitoring the whereabouts of identified residents through individual safety devices worn by them. PSW #102 stated safety devices worn by identified residents displayed on monitors to identify where residents were in the home and that identified residents requiring further interventions which were to be documented on a flow sheet at the nursing station. PSW #102 further identified resident #001 was known to him/her to have identified responsive behaviours. He/she reported resident #001's written plan of care identified that he/she wore a safety device and was to be provided an identified intervention by staff. by PSW staff. PSW #102 reported that he/she had not checked the safety device at the start of shift for resident #001, and had not completed identified interventions as outlined in the plan of care.

Interview with RPN #104 revealed that residents with the identified responsive behaviour required additional identified intervention which was to be documented on a flow sheet at the nursing station. RPN #104 stated the identified intervention for resident #001 had not been completed on the day the resident exited the home.

Interview with the DOC identified the homes expectation for the staff was to provide care to residents as directed in the plan of care. The DOC stated the plan of care was not followed by PSW #102 as the identified safety intervention outlined in resident #001's plan of care had not been completed during the identified shift on the date of when resident #001's exited from the home.

The licensee failed to ensure the care set out in the plan of care was provided to resident #001 as specified. [s. 6. (7)]

4. The home submitted a CIS report on an identified date of an allegation of abuse by PSW #117 towards resident #003. The report identified staff PSW #117 had been found in an identified manner in another resident's room during an identified shift and resident #003 was found self transferring.

Review of resident #003's clinical records identified a progress note, dated for the incident reported above, indicating that the resident was found by staff self transferring from bed.

Review of resident #003's written plan of care dated at the time of the incident, identified he/she required staff assistance for transferring. The written plan of care directed staff to complete an identified intervention while resident #003 was in bed. The written plan of care further indicated that staff were to ensure resident #003 was safe and comfortable when in bed.

Review of resident #003's flow sheet in point of care (POC) on the date of the incident identified PSW #117 had documented for the identified intervention at specified times to ensure resident #003 was in bed and safe.

Interview with the alleged, PSW #117 could not be conducted as the staff member was unavailable following an attempt to contact. Review of PSW #117 tracking detail of his/her safety for the date of the incident, identified he/she had entered resident #003's room for an identified length of time over an identified period of time. PSW #117 did not re-enter resident #003's room for remainder of the identified shift, contradicting documentation reviewed in POC as noted above.

Interview with the assistant director of care (ADOC) clarified that PSW #117 was not in resident #003's room after an identified time, and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #003.

Interview with RN #114, revealed registered staff were to check with PSW staff throughout the identified shift, after care rounds, and obtain report from them prior to shift change. RN #114 stated he/she had last checked on PSW # 117 at an approximate time, prior to break prior to break. RN #114 revealed he/she was unaware of PSW #117's whereabouts for the remainder of shift and did not see PSW #117 to obtain report before end of shift.

Interview with homes DOC and ADOC confirmed that resident #003 had not been provided care as identified in the plan throughout the identified shift on the date of the incident, by PSW #117.

The licensee failed to ensure the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

5. The home submitted a CIS report on an identified date, to the MOHLTC identifying an allegation of abuse by PSW #117 towards resident #004. The report identified PSW #117 had been found in an identified manner in another resident's room during an identified shift and resident #004 who was found in a manner of which care may not have been provided to the resident. The CIS report PSW and housekeeping staff stated that the residents' bedding and area in the room had been found to be in a specified manner.

Review of resident #004's written plan of care at the time of the incident, identified the resident required staff to an identified intervention at specified times during an identified shift.

Review of resident #004's clinical records identified a progress note which indicated he/she was found by staff in a specified manner. Review of the identified intervention flow sheet for resident #004 for the date of the incident, did not identify any documentation for the identified shift. Additional clinical records reviewed included a skin assessment which documented resident #004 had an area of altered skin integrity.

Interview with PSW #117 could not be conducted as the staff member was unavailable following an attempt to contact.

Review of PSW #117 tracking detail of his/her safety device for the date of the incident, identified he/she had entered resident #004's room for an identified number of minutes and over an identified period of hours. PSW #117 did not re-enter resident #004's room for remainder of the identified shift. The badge report further identified PSW #117 entered an identified room for a longer period of time over the identified shift. Review of resident #004's flow sheet in POC identified PSW #117 documented he/she provided care at an identified contradicting the record of the badge report.

During a staff interview, PSW #112 stated he/she found PSW #117 in an identified manner in an identified room at the beginning of the next identified shift.

Interview with PSW #118 and #124 reported care rounds were to be completed twice during the night shift and was to be documented for residents who were provided care during rounds.

RN #103 revealed he/she found resident #004 in the early part of the following shift with in a an identified manner.

Interview with RN #114, revealed registered staff were to check with PSW staff throughout the shift, after care rounds, and obtain report from them prior to shift change. RN #114 stated he/she had last checked on PSW # 117 at an approximate time prior to break. RN #114 revealed he/she was unaware of PSW #117's whereabouts for the remainder of shift and did not see PSW #117 to obtain report before end of shift.

Interview with the ADOC clarified that PSW #117 was not in resident #004's room at the identified time and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #004.

Interview with homes DOC and ADOC confirmed that resident #004 was not provided care as directed in the plan of care by PSW #117 who was found in an identified manner while in another residents room.

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

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The scope of the non-compliance is widespread
A review of the compliance history revealed that there had been previously issued a compliance order to O. Reg. 79/10, s. 6. to the licensee during inspection #2015_369153_0002 of April 24, 2015. [s. 6. (7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The home submitted a CIS report on an identified date, indicating that there had been an incident which had caused injury to a resident which had resulted in the resident being transferred to the hospital. A review of the above mentioned CIS indicated that during a transfer of resident #017 using a sit to stand mechanical lift, the resident's health condition changed which resulted in resident #017 falling. Resident #017 had been transferred to the hospital on an identified date, following the above mentioned incident and diagnosed with an identified injury. Resident #017 was provided appropriate treatment in hospital and returned to the home at a later date.

A review of resident #017's plan of care identified the resident as dependent and required the use of a sit to stand mechanical lift with two staff for all transfers. A record review of the above mentioned incident indicated that resident #017 had only been transferred with one staff member present.

Interviews with RPN’s #100, #109, and PSW #101 indicated that on the date of the incident, resident #017 had been transferred via a sit to stand lift with one staff member who had been an agency employee to assist. The above mentioned staff further indicated during the interview that the agency employee did not provide a safe transfer as resident #017 had been transferred by himself/herself and not with two staff members as the plan of care indicated for all transfers.

The Director of Care confirmed during an interview that the expectation is for all staff including agency staff, to follow the transfer logos when transferring residents to ensure residents are transferred safely and further confirmed that the staff member performed an unsafe transfer of resident #017 by not following the plan of care which had stated two staff members are to assist resident during all transfers.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk. The scope of the non-compliance is isolated. A review of the compliance history revealed that there had been no previously issued compliance order to O. Reg. 79/10, s. 36. to the licensee.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 :

The home submitted a CIS report on an identified, indicating that there had been an incident which had caused injury to a resident that resulted in the resident being transferred to the hospital.

A review of the above mentioned CIS indicated that resident #023 had been found on the floor in the hallway after ambulating with his/her mobility aide on an identified date at an identified time.

A review of the home's Falls Prevention and Management policy, #NUR-V-165, dated November 2011, directed registered nursing staff to inform the POA/SDM of all resident falls within one hour of the fall or first thing in the am if the fall occurs during the night shift.

A record review indicated that the resident continued to experience pain and had been ordered an identified test two days after the incident, and diagnosed with an identified injury. The records indicated that the substitute decision maker had not been contacted until the third day after the date of the incident.

Interviews with RPN's #100 and #110 indicated that after a resident falls the registered nursing staff are required to contact the POA/SDM to inform them of the incident.
An interview with the Director of Care indicated that the expectation of the home is to follow the above mentioned policy and inform the POA/SDM of any resident falls. The Director of Care further confirmed that the home did not comply with the above mentioned policy and did not ensure the POA/SDM had been notified after resident #023 had been found on the floor on the identified [s. 8. (1) (a),s. 8. (1) (b)]

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 registered staff comply with the homes policy, protocol, procedure, strategy, or system instituted or otherwise put in place to inform POA/SDM of all resident falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The home submitted a CIS report to the MOHLTC reporting a resident had exited from the home on an identified date. The CI report identified the resident had been away from the home for some time and was escorted back to the home by PSW #105.

Interviews with RPN #103 and #109, ENSM, and the former ESM revealed the doors leading to an identified area were open during identified months to residents allowing them to access and identified area. Interviews with these staff identified that the homes management would post a memo on the doors leading to the identified area identifying the time and dates when the doors would be unlocked for the residents.

Interview with the DOC and the administrator reiterated the home would open the doors leading from the home to the identified area at specified times. The DOC and administrator identified that a memo would be posted on the doors to inform staff that the doors would be open to residents to access the identified areas.

The homes policy titled "Door Alarm System" (Number NUR-VI-12, Dated February 2007) in place at the time of the incident was reviewed as part of this inspection. The policy identified that at specific times and under controlled conditions, patio and lounge exit doors may be deactivated for the purpose of activities (i.e. BBQ or air circulation). The policy did not indicate how staff would be made aware when the doors leading to the identified would be open to residents, when residents would have access to secure identified areas, or when the doors leading off the premises from the identified areas would be locked or unlocked. The policy did not identify when the doors leading from the home to the identified areas or the doors securing the identified areas would be locked or unlocked to permit or restrict unsupervised access to those areas by residents. [s. 9. (2)]

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 there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident has fallen, that they ensure that the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted a CIS report on an identified date, indicating that there had been an incident which had caused injury to a resident that resulted in the resident being transferred to the hospital.

A review of the above mentioned CIS indicated that resident #023 had been found on the floor in the hallway after ambulating with his/her identified mobility device on an identified date at an identified time.

Interviews with RPNs #100, #109 and #110 indicated that after a resident falls the registered nursing staff are required to complete an electronic fall assessment note template that is a comprehensive assessment.

A review of the progress notes indicated that resident #023 had not been assessed after the fall on the date of the incident using a clinically appropriate assessment. It had been indicated at that time that it had been an agency registered staff that had been working during that shift and had not completed the assessment as required.

An interview with the Director of Care indicated that the expectation of the home is to complete an electronic fall assessment note after every resident fall. The DOC acknowledged during the interview that the post fall note takes the registered staff through the required steps of what they need to do in their assessment to ensure their documentation is comprehensive. The DOC confirmed that resident #023 had not received a post fall assessment following the fall on the date of the incident. [s. 49. (2)]

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 when a resident has fallen, he/she are assessed, and if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

Issued on this 15th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOVAIRIA AWAN (648), CECILIA FULTON (618), JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2017_653648_0004
Log No. / Registre no:	006941-16, 014481-16, 023099-16, 026884-16, 027309-16, 031726-16, 004526-17, 005987-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 5, 2017
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

To THE ONTARIO MISSION OF THE DEAF, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

Within two weeks of receipt of this order, the licensee shall:

Prepare, submit and implement a plan to ensure preventative maintenance is applied to all exits leading out of the home to secure and non secure areas and the identification of the individuals responsible for managing exits leading out of the home to secure and non secure areas.

The plan shall include an auditing system to ensure that exits leading outside the home are equipped with appropriate locks and in working order. Please submit the plan to jovairia.awan@ontario.ca.

Grounds / Motifs :

1. The home submitted critical incident system (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) reporting resident#001 had exited from the home on an identified date. The CI report identified resident #001 had been away from the home for some time and was escorted back to the home by PSW #105.

A review of resident #001's progress notes and written plan of care identified the resident to have exhibited an identified responsive behaviour and had previously exited the home.

Observations conducted with RPN #109, the ESNM and DOC identified the doors leading from two identified areas of the home lead to identified individual secure areas. Each identified area was further identified as having a maglocked door leading off the premises.

Interview with PSW #105 revealed he/she found resident #001 off the premises of the home after completing his/her shift on the date of the incident. PSW #105 escorted resident #001 back to the home and reported he/she found an identified door leading off the premises from another identified area open. PSW #105 stated he/she identified the unlocked door in the identified area to management, and demonstrated it was not locking when closed and that it could be pushed open. Upon further inquiry, PSW #105 reported the doors which resident #001 passed through, leading from the home to an identified area were unlocked during an identified season. PSW #105 was unaware if the door through which the resident had exited had been checked prior to the incident by any other staff in the home.

Interviews with RPN #103 and #109 revealed the doors leading to the identified area were open during identified months to residents allowing them to access the doors in the identified area. RPN #109 reported staff were not provided direction to check if the doors in the identified area leading off the premises were locked when the doors to the identified areas were unlocked for residents.

Interview with the EC revealed the doors leading out of the identified area and all doors in the home were fitted with maglocks. The EC was unable to demonstrate if the maglocks on the doors in the identified area had been routinely checked to ensure they were locked when the residents had access to the identified area.

Interview with the ENSM reported the nursing staff were expected to conduct routine checks of the homes internal doors. The ENSM was unable to demonstrate how and how often the doors leading out of the homes identified area were checked to ensure they were locked when the residents had access to the identified area. Interview with the former ESM revealed the home unlocked the doors leading into the area from the home during identified months for the residents to access the identified area. The ESM reported that the home did not conduct routine audits or preventative maintenance on the doors leading outside of the identified area to ensure the maglocks were functional when residents had access to the identified area.

Interview with the DOC acknowledged the door through which resident #001 had exited from had malfunctioned and was not locked at the time of the incident. Interview with the homes administrator revealed staff would not be aware if the doors leading outside of the identified area were locked unless they were to manually check them. The administrator identified the doors were to be checked

by the EC but was unable to demonstrate the frequency of these checks, and unable to demonstrate how nursing staff would ensure the identified area was secure when the residents had access during the identified time period through unlocked doors leading from the home to the identified area.

The home failed the ensure the home was a safe and secure environmental for resident #001.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk. The scope of the non-compliance is isolated. A review of the compliance history revealed that there had been previously issued non compliance to O. Reg. 79/10, s. 5 to the licensee during inspection #2015_369153_0002 of April 24, 2015 (648)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

1. Within one week of receipt of this order review resident #001, #003, #004, and #017's plan of care with all direct care staff responsible for the resident's care to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

2. Develop and implement a quality improvement process to ensure that all residents, #001, #003, #004, and #017, receive the care as specified in his/her plan of care.

3. Document all required steps in 1-2 noted above.

The licensee shall prepare and submit a plan that includes tasks 1-2 and the person(s) responsible for completing the tasks. The plan is to be submitted to jovairia.awan@ontario.ca

Grounds / Motifs :

1. The home submitted a CIS report on an identified date, to the MOHLTC identifying an allegation of abuse by PSW #117 towards resident #004. The report identified PSW #117 had been found in an identified manner in another resident's room during an identified shift and resident #004 who was found in a manner of which care may not have been provided to the resident. The CIS report PSW and housekeeping staff stated that the residents' bedding and area in the room had been found to be in a specified manner.

Review of resident #004's written plan of care at the time of the incident,

identified the resident required staff to an identified intervention at specified times during an identified shift.

Review of resident #004's clinical records identified a progress note which indicated he/she was found by staff in a specified manner. Review of the identified intervention flow sheet for resident #004 for the date of the incident, did not identify any documentation for the identified shift. Additional clinical records reviewed included a skin assessment which documented resident #004 had an area of altered skin integrity.

Interview with PSW #117 could not be conducted as the staff member was unavailable following an attempt to contact.

Review of PSW #117 tracking detail of his/her safety device for the date of the incident, identified he/she had entered resident #004's room for an identified number of minutes and over an identified period of hours. PSW #117 did not re-enter resident #004's room for remainder of the identified shift. The badge report further identified PSW #117 entered an identified room for a longer period of time over the identified shift. Review of resident #004's flow sheet in POC identified PSW #117 documented he/she provided care at an identified contradicting the record of the badge report.

During a staff interview, PSW #112 stated he/she found PSW #117 in an identified manner in an identified room at the beginning of the next identified shift.

Interview with PSW #118 and #124 reported care rounds were to be completed twice during the night shift and was to be documented for residents who were provided care during rounds.

RN #103 revealed he/she found resident #004 in the early part of the following shift with in a an identified manner.

Interview with RN #114, revealed registered staff were to check with PSW staff throughout the shift, after care rounds, and obtain report from them prior to shift change. RN #114 stated he/she had last checked on PSW # 117 at an approximate time prior to break. RN #114 revealed he/she was unaware of PSW #117's whereabouts for the remainder of shift and did not see PSW #117 to obtain report before end of shift.

Interview with the ADOC clarified that PSW #117 was not in resident #004's room at the identified time and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #004.

Interview with homes DOC and ADOC confirmed that resident #004 was not provided care as directed in the plan of care by PSW #117 who was found in an identified manner while in another residents room.

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

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The scope of the non-compliance is widespread
A review of the compliance history revealed that there had been previously issued a compliance order to O. Reg. 79/10, s. 6. to the licensee during inspection #2015_369153_0002 of April 24, 2015. [s. 6. (7)]
(648)

2. The home submitted a CIS report on an identified date of an allegation of abuse by PSW #117 towards resident #003. The report identified staff PSW #117 had been found in an identified manner in another resident's room during an identified shift and resident #003 was found self transferring.

Review of resident #003's clinical records identified a progress note, dated for the incident reported above, indicating that the resident was found by staff self transferring from bed.

Review of resident #003's written plan of care dated at the time of the incident, identified he/she required staff assistance for transferring. The written plan of care directed staff to complete an identified intervention while resident #003 was in bed. The written plan of care further indicated that staff were to ensure resident #003 was safe and comfortable when in bed.

Review of resident #003's flow sheet in point of care (POC) on the date of the incident identified PSW #117 had documented for the identified intervention at specified times to ensure resident #003 was in bed and safe.

Interview with the alleged, PSW #117 could not be conducted as the staff member was unavailable following an attempt to contact. Review of PSW #117 tracking detail of his/her safety for the date of the incident, identified he/she had entered resident #003's room for an identified length of time over an identified period of time. PSW #117 did not re-enter resident #003's room for remainder of the identified shift, contradicting documentation reviewed in POC as noted above.

Interview with the assistant director of care (ADOC) clarified that PSW #117 was not in resident #003's room after an identified time, and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #003.

Interview with RN #114, revealed registered staff were to check with PSW staff throughout the identified shift, after care rounds, and obtain report from them prior to shift change. RN #114 stated he/she had last checked on PSW # 117 at an approximate time, prior to break prior to break. RN #114 revealed he/she was unaware of PSW #117's whereabouts for the remainder of shift and did not see PSW #117 to obtain report before end of shift.

Interview with homes DOC and ADOC confirmed that resident #003 had not been provided care as identified in the plan throughout the identified shift on the date of the incident, by PSW #117.

The licensee failed to ensure the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]
(648)

3. The home submitted a CIS report to the MOHLTC reporting resident #001 had exited from the home on an identified date. The CI report identified resident #001 had been away from the home for some time and was escorted back to the home by PSW #105.

Record review of resident #001's clinical records identified progress notes indicating the resident had exhibited an identified responsive behaviour on an identified number of occasions.

A progress note identified that resident #001 had left the grounds through an identified door. He/she was found by staff in an identified area attempting to

leave the home. An identified safety intervention was instituted for resident #001 on an identified date following this incident.

The home submitted another CIS on a later date to the MOHTLC reporting resident #001 had exited from the home through an identified exit from an identified area on an identified date. The CI report identified resident #001's whereabouts were unknown to staff for an identified period of time

Review of resident #001's written plan of care at the time of the incident, identified the resident with an identified responsive behaviour. The interventions to manage the an identified responsive behaviour directed staff to an identified measure to ensure that resident #001 was safe.

Review of resident #001's clinical records identified a flow sheet for which staff were to enter the safety measure. The flow sheet did not identify documentation of entries for the identified safety measure on the date of the incident for an identified time frame for resident #001.

Interview with PSW #105 revealed he/she had found resident #001 in an identified area away from the home. PSW #105 reported he/she escorted the resident back the home upon realizing he/she had exited.

Interview with PSW #102 revealed he/she was on duty during the an identified shift and was assigned resident #001's home area on the day of the incident. PSW #102 reported that an identified safety measure was to be completed for residents at the start of shift and throughout by monitoring the whereabouts of identified residents through individual safety devices worn by them. PSW #102 stated safety devices worn by identified residents displayed on monitors to identify where residents were in the home and that identified residents requiring further interventions which were to be documented on a flow sheet at the nursing station. PSW #102 further identified resident #001 was known to him/her to have identified responsive behaviours. He/she reported resident #001's written plan of care identified that he/she wore a safety device and was to be provided an identified intervention by staff. by PSW staff. PSW #102 reported that he/she had not checked the safety device at the start of shift for resident #001, and had not completed identified interventions as outlined in the plan of care.

Interview with RPN #104 revealed that residents with the identified responsive

behaviour required additional identified intervention which was to be documented on a flow sheet at the nursing station. RPN #104 stated the identified intervention for resident #001 had not been completed on the day the resident exited the home.

Interview with the DOC identified the homes expectation for the staff was to provide care to residents as directed in the plan of care. The DOC stated the plan of care was not followed by PSW #102 as the identified safety intervention outlined in resident #001's plan of care had not been completed during the identified shift on the date of when resident #001's exited from the home.

The licensee failed to ensure the care set out in the plan of care was provided to resident #001 as specified. [s. 6. (7)]
(648)

4. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The home submitted a CIS report to the MOHLTC on an identified date, indicating that an incident occurred that had caused injury to a resident that resulted in the resident being transferred to the hospital. A review of the above mentioned CIS indicated that during a transfer of resident #017 using a sit to stand mechanical lift, the health changed. Resident #017 was transferred to the hospital on an identified date and was diagnosed with an identified injury. Resident #017 received the appropriate care in hospital and returned to the home.

A review of resident #017's plan of care identified the resident as dependent and required the use of a sit to stand mechanical lift with two staff for all transfers.

A record review of the above mentioned incident indicated that resident #017 had only been transferred with one staff member present.

Interviews with RPN's #100, #109, and PSW #101 indicated that on the date of the incident, resident #017 had been transferred via a sit to stand lift with one staff member who had been an agency employee to assist. The above mentioned staff further indicated during an interview that the agency employee did not provide a safe transfer as resident #017 had been transferred by himself/herself and not with two staff members as the plan of care indicated.

An interview with the DOC confirmed that all interventions in the plan of care for resident #017 are expected to be followed. The DOC further confirmed that when resident #017 had been transferred by one staff using the mechanical sit to stand lift the staff member did not provide the care to resident #017 as specified in the plan of care. [s. 6. (7)]

(647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

Within two weeks of receipt of this order, the licensee shall:

Prepare, submit and implement a plan to ensure that all staff in the home receive training related to safe transferring and positioning techniques when assisting residents.

The plan shall include, and not limited to the review of the home's employee orientation package to ensure information relating to safe transferring and positioning techniques when assisting residents is included for all new employees. The plan is to be submitted to jennifer.brown6@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The home submitted a CIS report on an identified date, indicating that there had been an incident which had caused injury to a resident which had resulted in the resident being transferred to the hospital. A review of the above mentioned CIS indicated that during a transfer of resident #017 using a sit to stand mechanical lift, the resident's health condition changed which resulted in resident #017 falling. Resident #017 had been transferred to the hospital on an identified date, following the above mentioned incident and diagnosed with an identified injury. Resident #017 was provided appropriate treatment in hospital and returned to the home at a later date.

A review of resident #017's plan of care identified the resident as dependent and required the use of a sit to stand mechanical lift with two staff for all transfers. A

record review of the above mentioned incident indicated that resident #017 had only been transferred with one staff member present.

Interviews with RPN's #100, #109, and PSW #101 indicated that on the date of the incident, resident #017 had been transferred via a sit to stand lift with one staff member who had been an agency employee to assist. The above mentioned staff further indicated during the interview that the agency employee did not provide a safe transfer as resident #017 had been transferred by himself/herself and not with two staff members as the plan of care indicated for all transfers.

The Director of Care confirmed during an interview that the expectation is for all staff including agency staff, to follow the transfer logos when transferring residents to ensure residents are transferred safely and further confirmed that the staff member performed an unsafe transfer of resident #017 by not following the plan of care which had stated two staff members are to assist resident during all transfers.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk. The scope of the non-compliance is isolated. A review of the compliance history revealed that there had been no previously issued compliance order to O. Reg. 79/10, s. 36. to the licensee. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jovairia Awan

Service Area Office /
Bureau régional de services : Toronto Service Area Office