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 14, 2017	2017_646618_0012	008457-17, 009482-17, 009554-17	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

CECILIA FULTON (618)

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): May 16, 17, 18, 23 and 24, 2017.

The following Critical Incident inspections were conducted during this inspection: Log # 008457-17, 009554-17 and 009482-17.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (A-DOC), physician, co-op student, registered nursing staff, personal support workers, housekeeper, pharmacy consultant, Substitute Decision Maker (SDM) and Residents.

During the course of the inspection, the inspector(s) observed residents and staff to resident interaction and the provision of resident care in the resident home areas, and reviewed resident health records, video recordings and home policies.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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 there was a written plan of care for each residents that sets out clear directions to staff and others who provide direct care to the resident.

This Critical incident inspection was initiated to inspect items identified in an identified intake log. The home submitted a Critical Incident Report (CIS), in an identified date in, related to a resident abuse.

A review of resident #003's clinical records revealed that on an identified date in 2017, the physician had ordered an intervention which was to be in place for one week. The following month, a subsequent order altered the date of the intervention.

Interview with registered staff #105 confirmed that the order for the intervention, dated the second month, was to be transcribed into the resident's Electronic Medication Administration Record (E-MAR) or Electronic Treatment Administration Record (E-TAR) so that the order was captured and the procedure is scheduled.

Review of the, E-MARs or E-TARs for both identified months did not include the intervention.

Review of the resident's written plan of care stated that the resident required the prescribed intervention , however no dates for that scheduled change were identified.

The home entered this information into E-TAR later in the second month and assigned a

date for the intervention.

Further to resident #003's care needs, there was no documentation in the resident's plan of care to indicate when the resident's tasks were required in relation to his/her identified care requirements.

Interview with PSW #100 revealed that they believe the task should have set times. PSW #100 was unable to identify the set times for this task.

Interview with Director of Care (DOC) revealed that the task is to occur at the change of shift and the results are to be recorded in Point of Care (POC).

Review of the home's policy, NUR-V-75 dated March 2008, stated specific times for this task to be performed and direction regarding documentation.

Review of the POC documentation did not include any documentation of this task.

Interview with DOC confirmed that it is the expectation when a resident required this intervention that the task for management of the intervention is to be performed at the end of each shift and the documentation done. The DOC confirmed that this information was not in the resident's plan of care and that there was no documentation to indicate that this care was being provided.

Resident #003 was also receiving another therapy.

Review of clinical records revealed a physician order written on an the first identified date in 2017, for the therapy.

The physician order was changed on an the subsequent month in 2017. No parameters were provided for staff to use when assessing the resident's need for the identified therapy.

Interview with registered staff #106 revealed that the therapy orders are to be transcribed on the E-Mar for ongoing documentation.

Review of the resident #003's E-MARs for the first and second identified months revealed that no orders for this therapy had ever been transcribed.

The home became aware of this issue following interviews the Inspector conducted with staff and the order for the therapy was entered into the E-MAR.

Review of resident #003's written plan of care and Kardex did not include any mention of this ongoing therapy.

Interview with Assistant Director of Care confirmed that these orders should have been put onto the E-MAR and that they had not thus leaving the staff with no information or clear direction on the delivery of this care. [s. 6. (1) (c)]

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

This Critical Incident inspection was initiated to inspect items identified in an identified intake log. The home submitted a CIS an identified date in 2017, related to alleged staff to resident abuse.

Record review revealed that on an identified date 2017, specific therapy orders were received for resident #003.

Record review revealed that this order had not been transcribed into the E-MAR as is the usual practice.

Record review also revealed that since the date of the order there were an identified number of note entries for identified dates in 2017, each documenting that the therapy was in use however not as prescribed by the physician.

Interview with registered staff #106 confirmed that the order for this therapy had not been transcribed into the E-Mar when the order changed on an identified date in 2017. [s. 6. (7)]

Issued on this 30th day of June, 2017

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

Original report signed by the inspector.