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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2018	2018_565647_0025	021622-18	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

JENNIFER BROWN (647), CHAD CAMPS (609), SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 27 - 31 and September 3 - 4, 2018.

The following critical incident (CIS) was conducted during this inspection related to transferring and positioning, and prevention of abuse and neglect.

The following complaint was completed during this inspection related to administration of drugs, responsive behaviours, and plan of care.

The following follow-up to compliance orders (CO) were completed during this inspection:
CO #001 served to the licensee during inspection 2017_655679_0015 related to LTCHA, 2007, c. 8, s. 6 (7), plan of care;
CO #001 served to the licensee during inspection 2018_491647_0001 related to O. Reg 79/10, s. 21, maintain home at minimum temperature of 22 degrees Celsius; and,
CO #002 served to the licensee during inspection 2018_491647_0001 related to O. Reg 79/10, s. 230 (4), Emergency plans.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Communicator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Chaplain, External contract provider, Housekeeper, Behaviour Support Outreach (BSO), Residents, Family Members and Substitute Decision Makers.

During the course of the inspection, the inspector(s) conducted observation in resident home areas, observation of care delivery processes including medication administration, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 21.	CO #001	2018_491647_0001	647
O.Reg 79/10 s. 230. (4)	CO #002	2018_491647_0001	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_655679_0015	647

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home’s written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #609 reviewed a Critical Incident (CIS) report that was submitted by the home to the Director, which outlined that direct care staff members #108 and #109 left resident #011 in a specific area for an extended period of time without providing the resident the assistance needed.

The CIS report indicated that resident #011 was found in the area visibly upset.

A review of resident #011’s health care records which included the progress notes, indicated that Registered staff member #113 observed the resident unattended in the area. Resident #011 was visibly upset and the Registered staff member remained with resident #011 to calm them down. The resident kept asking “Why was I left for so long?"

Ontario Regulation (O. Reg.) 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview with direct care staff member #109, they verified that they were assigned resident #011, when they along with direct care staff member #108 assisted the resident to the area.

Direct care staff member #109 explained that after assisting resident #011 to the area, they left the resident alone in the area in order to respond to other call bells. They went on to state that they lost track of time and assisted the resident out of the area after an extended period of time.

A review of the home’s policy titled “Zero Tolerance of Abuse and Neglect of Residents” last revised January 30, 2017, indicated that the home was committed to zero tolerance of abuse or neglect of its residents.

During an interview with the Assistant Director of Care (ADOC), a review of the home’s internal investigation of the CIS was conducted. The home’s internal investigation substantiated the neglect of resident #011 by direct care staff members' #108 and #109 when they were left alone in a specific area for an extended period of time.

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 home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian, meets annually to evaluate the effectiveness of the medication management system and recommend any changes in order to improve the program.

Inspector #692 reviewed a medication incident report which indicated that the physician ordered a medication as needed for resident #009. The physician order did not include the correct dosage to administer. The incident was detected by the pharmacy provider and was corrected prior to administering to resident #009.

The Inspector requested the licensee's annual evaluation of the medication management system.

Review of the annual medication management system evaluation titled "Program Evaluation" did not include written documentation of an evaluation by the interdisciplinary team.

During an interview with the DOC, they confirmed the licensee did not complete an annual evaluation of the effectiveness of the medication management system and did not recommend any changes necessary to improve the system with the above mentioned disciplines. The DOC stated they did not realize that this was to be completed annually.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a quarterly review of all medication incidents, including a written record of the analysis and any changes or improvements was completed.

Inspector #692 reviewed a medication incident report which indicated that the physician ordered medication, as needed, for resident #009. The physician order did not include the correct dosage to administer. The incident was detected by the pharmacy provider and was corrected prior to administering to resident #009.

The Inspector requested the licensee's quarterly analysis of the medication incidents from the previous quarter.

Review of the Quality Council Meeting minutes from the previous quarter, demonstrated they did not include written documentation of an analysis of that quarter's medication incidents, including recommended changes or improvements.

During an interview with the DOC, they confirmed the licensee does not complete a written quarterly analysis of the medication incidents. The DOC stated they did not realize that was to be completed quarterly.

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Issued on this 10th day of September, 2018

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

Original report signed by the inspector.