Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 15, 2010, January 10 & 13, 2011	**2010_109_2967_15Dec134626** **2010_101_2967_15Dec134607**	Critical Incident Log # T-3149

Licensee/Titulaire
The Ontario Mission of the Deaf, 2395 Bayview Avenue, North York, M2L 1A2
Phone: 416-449-9651
Fax: 416-449-8881

Long-Term Care Home/Foyer de soins de longue durée
Bob Rumball Home For The Deaf, 1 Royal Parkside Drive, Barrie, ON L4M 0C4
Phone: 705-719-6700

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

Susan Squires – 109 and Amanda Williams- 101

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident
During the course of the inspection, the inspector spoke with: Administrator, Director of Resident Care, registered nursing staff, and the Environmental Service Manager

During the course of the inspection, the inspectors: Reviewed the health record, inspected the resident room/bed, conducted measurements of the resident bed, reviewed the maintenance requisition records, the call bell monitoring system and its policy and procedure.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death Inspection Protocol.
Safe and Secure

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

9 WN
1 VPC
8 CO- #001, 002, 003, 004, 005, 006, 007, 008

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)	
Definitions/Définitions **WN** – Written Notifications/Avis écrit **VPC** – Voluntary Plan of Correction/Plan de redressement volontaire **DR** – Director Referral/Régisseur envoyé **CO** – Compliance Order/Ordres de conformité **WAO** – Work and Activity Order/Ordres: travaux et activités	
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c. 8, s. 19 (1). Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

Findings:

A resident's plan of care stated that he required a pillow to be placed between his head and the bed rail for safety.

1. The staff on duty on informed inspectors that the pillow that was required to be placed between resident's head and the bed rails had not been replaced after the last rounds from the staff.
2. The licensee had modified two resident's bedrails. Following the date of modification, the licensee did not implement routine, preventative or remedial maintenance on the modified bedrails to ensure the bedrails remained in a safe position and condition.

Inspector ID #:	109 and 101

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 for ensuring that all staff are aware of their responsibility in caring and responding to high risk residents to ensure that no residents are neglected. The plan is to be implemented voluntarily.

WN # 2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6(4)(a) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
(b) in the development and implementation of the plan of care to that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings:

1. There were conflicting assessments between nursing staff regarding the safe positioning of an identified resident. There was inconsistent practice confirmed through staff interviews.

Inspector ID #:	109

Additional Required Actions:

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

WN # 3: The Licensee has failed to comply with **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).**

Findings:
The care for an identified resident was not delivered in a safe manner as identified in the plan of care.

Inspector ID #:	109

Additional Required Actions:

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

WN # 4: The Licensee has failed to comply with **O. Reg. 79/10 s. 17 (1) (b). Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Findings:

1. A resident staff communication system fob (i.e. "GPS Badge") was noted to be inoperable for an extended period of time in the month of December, 2010. The malfunctioning system was identified by the nursing staff but not communicated to appropriate individuals.

Inspector ID #:	109 and 101

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 staff effectively communicate malfunctioning equipment to the Environmental Services Manager for prompt correction. The plan is to be implemented voluntarily.

CO# - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN # 5: 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.

Findings:
1. A high risk resident was not positioned safely in bed..

Inspector ID #:	109

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Inspector ID #:	109

WN # 6: The Licensee has failed to comply with **O. Reg. 79/10 s. 15 (1) (a) (b). Every licensee of a long-term care home shall ensure that where bed rails are used,**
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Findings:
1. Entrapment hazard zones 1 and 2 as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"* was noted to be present on an identified resident bed with bedrails when the head of the bed was in the elevated position.
2. A residents' bed was identified to have a zone 6 entrapment hazard as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".*
3. Resident beds (Make- "Carroll") were noted throughout unit D4 to have potential zone 6 entrapment hazards as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"* when elevated to a 45 degree angle or less and with 1/4 bedrails.
4. The home does not assess residents or evaluate their bed systems in accordance with evidenced based practices. The home confirmed that there is no formalized evaluation system currently in place.

Inspector ID #:	101

Additional Required Actions:

CO # - 001 was served on the licensee December 15, 2010. Refer to the "Order(s) of the Inspector" form.
CO# - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN # 7: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.15 (2) (c). Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings:
1. Potential zones of entrapment were noted on two identified resident beds where a therapeutic mattress and bedrails were present creating unsafe conditions.
2. The licensee had modified two resident bedrails. Following the date of modification, the licensee did not implement routine, preventative or remedial maintenance on the modified bedrails to ensure the bedrails remained in a safe position and condition.

3. The "GPS badge" for a resident was identified to be inoperable for 15 days. At the time of the inspection the Environmental Services Manager, charge nurse, and Director of Care were unaware that his GPS Badge was inoperable.

Inspector ID #:	**109 & 101**

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN # 8: The Licensee has failed to comply with **O. Reg. 79/10 s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.**

Findings:

1. Identified ARRO bed and ECHO bed had assist rails that were removed and replaced with full length bed rails that did not fit the beds appropriately to reduce the risk of entrapment or other safety risks and therefore not in accordance with manufacturer's instructions.
2. The above stated resident bed full length bedrails were not maintained as per manufacturer's specifications to ensure the bedrails were positioned in a manner to prevent potential entrapment and other hazards. The home did not have a maintenance program in place to ensure the altered ECHO and ARRO type bedrails were maintained in a manner to ensure resident safety as per manufacturers' instructions.
3. The bedrails for the identified resident beds were altered from the manufacturers' specifications and instructions.

Inspector ID #:	101

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
O. Reg 79/10, s. 15(1)	CO	001	2010_101_2967_15Dec134607	101

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: Date:	**Date of Report:** (if different from date(s) of inspection). Feb 3/2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Susan Squires Amanda Williams	**Inspector ID #**	109 101
Log #:	T-3149		
Inspection Report #:	2010_109_2967_15Dec134626 2010_101_2967_15Dec134607		
Type of Inspection:	Critical Incident		
Date of Inspection:	December 15, 2010, January 10 & 13, 2011		
Licensee:	The Ontario Mission of the Deaf, 2395 Bayview Avenue, North York, M2L 1A2 Phone: 416-449-9651 Fax: 416-449-8881		
LTC Home:	Bob Rumball Home For The Deaf, 1 Royal Parkside Drive, Barrie, ON L4M 0C4 Phone: 705-719-6700		
Name of Administrator:	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 #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, c. 8, s. 6 (4) (a). The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
(b) in the development and implementation of the plan of care to that the different aspects of care are integrated and are consistent with and complement each other. **2007, c. 8, s. 6 (4).**

Order:
The licensee shall ensure that the staff and others involved in the different aspects of care of the resident integrate assessments and plans of care so that they are consistent and complement each other in the safe delivery of care.

Grounds:
There were conflicting assessments between nursing staff on the night shift regarding the safe positioning of a resident.

1. Staff on one rotation provided a different intervention than the staff on the other rotation.

This order must be complied with by:	April 4, 2011		
Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 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:
The licensee shall ensure that the care set out in the plan is delivered to residents in a safe manner as specified in the plan of care by all staff.

Grounds:
The care for an identified resident was not delivered in a safe manner as identified in the plan of care.

This order must be complied with by:	February 25, 2011		
Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10 s. 17 (1) (b). Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Order:
The licensee shall ensure that the call communication system ("GPS system and badge") is on at all times, monitored, communicated and repaired when inoperable or not at full capacity.

Grounds:
1. An identified resident-staff communication system fob (i.e. "GPS Badge") was noted to be inoperable for 15 days. The malfunctioning GPS Badge was not communicated as per the Home's policy and procedure.

This order must be complied with by:	Immediately		
Order #:	005	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: 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.

Order:
The licensee shall ensure that all staff are using safe positioning devices or techniques with assisting all at risk residents.

Grounds:
An identified high risk resident was not positioned safely in bed.

This order must be complied with by:	Immediately		
Order #:	006	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10 s. 15 (1) (a) (b). Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Order:
1. The licensee shall assess all residents and evaluate their beds to ensure resident entrapment and all other potential hazards from beds with bedrails are mitigated.
2. The licensee shall develop a system to assess residents and evaluate their beds with bedrails using an evidenced based practice or prevailing practices.

Grounds:
1. An identified resident bed was noted to have a zone 6 entrapment hazard as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".*
2. Resident beds (Make- "Carroll") were noted throughout unit D4 to have potential zone 6 entrapment hazards as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"* when elevated to a 45 degree angle or less and with 1/4 bedrails.
3. The home does not assess residents or evaluate their bed systems in accordance with evidenced based practices. The Administrator- Shirley Cassel confirmed that there is no formalized evaluation system currently in place.

This order must be complied with by:	January 28, 2011		
Order #:	007	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8, s.15 (2) (c). Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order:
The license shall develop and implement routine, preventive and remedial practices to ensure furnishings and equipment are maintained in safe condition and in a good state of repair.

Grounds:

1. Potential zones of entrapment were noted on resident beds where a therapeutic mattress and bedrails were present creating unsafe conditions.
2. Two identified resident beds were modified. Following the date of modification, the licensee did not implement routine, preventative or remedial maintenance on the modified beds to ensure the bedrails remained in a safe position and condition.
3. The "GPS badge" for an identified resident was noted to be inoperable for 15 days. At the time of the inspection the Environmental Services Manager, charge nurse, or Director of Care were unaware that his GPS Badge was inoperable.

This order must be complied with by:	February 25, 2011

Order #:	008	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10 s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Order:
The licensee shall ensure that manufacturer's instructions and specifications are followed at all times pertaining to resident beds throughout the home.

Grounds:

1. Identified "ARRO" and "ECHO beds had assist rails that were removed and replaced with full length bed rails that did not fit the beds appropriately to reduce the risk of entrapment or other safety risks and therefore not in accordance with manufacturer's instructions.
2. The above mentioned resident beds full length bedrails were not maintained as per manufacturer's specifications to ensure the bedrails were positioned in a manner to prevent potential entrapment and other hazards. The home did not have a maintenance program in place to ensure the altered ECHO and ARRO type beds with bedrails were maintained in a manner to ensure resident safety as per manufacturers' instructions.
3. The bedrails for two resident beds were altered from the manufacturers' specifications and instructions.

This order must be complied with by:	Immediately

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 3 day of Februar , ~~2010~~. 2011	
Signature of Inspector:	
Name of Inspector:	Susan Squires & Amanda Williams
Service Area Office:	TSAO