

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2020	2020_853692_0009	019553-20	Complaint

Licensee/Titulaire de permis

The Ontario Mission of the Deaf
2395 Bayview Avenue North York ON M2L 1A2

Long-Term Care Home/Foyer de soins de longue durée

Bob Rumball Home for The Deaf
1 Royal Parkside Drive Barrie ON L4M 0C4

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 27 and 30, and December 1, 2020.

The following intake was inspected upon during this Complaint Inspection:

-One log, which was related to a complaint that was submitted to the Director related to an allegation of the home being neglectful when providing care for altered skin integrity.

A Follow Up Inspection #2020_853692_0010 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was given an opportunity to participate in the development and implementation of the resident's plan of care regarding the worsening of a wound.

A complaint was submitted to the Director regarding concerns with a resident's wound, as the wound had worsened and the home had not notified the resident's SDM.

The home's compliant log indicated the resident's SDM had not been notified when there was a change with the resident's wound. During a review of the resident's electronic progress notes, the Inspector was unable to locate any documentation that had indicated that the resident's SDM had been notified when the resident's wound had worsened.

It was determined by the Director of Care (DOC) that the registered staff had not updated the resident's SDM at the time when there was a change with the wound; therefore, the SDM was not able to participate in the resident's plan of care.

Sources: resident's electronic health records; the home's Complaint Investigation form; Skin and Wound Care policy; interviews with the complainant, DOC, and other staff. [s. 6. (5)]

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 ensuring that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 3rd day of December, 2020

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

Original report signed by the inspector.