



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8ième étage
TORONTO, ON, M4V-2Y7
Téléphone: (416) 325-9297
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 11, 12, 13, 17, 18, 19, 25, Nov 8, 10, 16, 2011; 2011_101174_0010; Critical Incident

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

NANCY A. BAILEY (174)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Clinical Nurse Manager, Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Home's Interpreter,

During the course of the inspection, the inspector(s) Conducted a clinical record review
Reviewed pertinent policy and procedures
Reviewed staff training records

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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>Legendé</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 O.Reg 79/10, s. 53. Responsive behaviours
Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that actions were taken to respond to the needs of the a resident exhibiting responsive behaviours, including reassessment of the resident by registered staff members when the resident continued to remain agitated for the majority of the shift. (53(4)b)
2. The licensee did not ensure that the responses to the interventions put in place were documented by the registered staff when the identified resident was agitated and physically aggressive and then again when 2 personal support workers restrained the resident. (53(4)c)

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 actions taken to respond to the needs of the resident with responsive behaviours including the response to the interventions are documented., to be implemented voluntarily.

WN #2: 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 subsections:

- s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
- (a) shall provide that abuse and neglect are not to be tolerated;
 - (b) shall clearly set out what constitutes abuse and neglect;
 - (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
 - (d) shall contain an explanation of the duty under section 24 to make mandatory reports;
 - (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
 - (f) shall set out the consequences for those who abuse or neglect residents;
 - (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
 - (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).
-

Findings/Faits saillants :

1. Home's Abuse and Neglect of a Resident Policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. The home's policy does explain that a person who has reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, shall immediately report the suspicion and the information upon which it is based to the Director, and that failure by staff to report is an offence under the law.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

- 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/Faits saillants :

1. The licensee failed to protect a resident from staff to resident abuse and neglect.

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 shall protect residents from abuse from anyone and shall ensure that the residents are not neglected by the licensee or staff., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

- s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).
-

Findings/Faits saillants :

1. The licensee did not ensure that all drugs were administered to an identified resident in accordance with the directions for use by the prescriber. The registered staff did not provide the full dosage of the medication as ordered by the physician.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee did not ensure that the Substitute Decision Makers for an identified resident were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that could potentially be detrimental to the resident's health and well-being, nor were the Substitute Decision Makers notified of an alleged abuse incident immediately upon the completion of the investigation.

Issued on this 16th day of November, 2011

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

