Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 9, 2024

Inspection Number: 2023-1450-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Ontario Mission of the Deaf

Long Term Care Home and City: Bob Rumball Home for The Deaf, Barrie

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.01.18 11:16:46 -05'00'

Additional Inspector(s)
Craig Michie (000690)
Sharon Perry (155)
Daniela Lupu (758)
Nuzhat Uddin (532)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 28-30, December 1, 4-8, and 12-14, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake: #00092103, related to a medication incident
- Intake: #00092112, related to fall prevention
- Intake: #00093647, related to continence care, skin and wound care and housekeeping services
- Intake: #00096815, related to an allegation of abuse towards a resident

· Intake: #00098295, related to improper transfer of a resident
· Intake: #00102743, COVID outbreak

The following intake(s) were completed in this complaint inspection:
· Intake: #00098892, related to improper care of a resident
· Intake: #00099982, related to continence care and resident's bill of rights
· Intake: #00102977, related to infection prevention and control (IPAC), resident's bill of rights, responsive behaviours and dining and snack service
· Intake: #00103333, related to the home's IPAC program

The following **Inspection Protocols** were used during this inspection:

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week.

Rational and Summary

A resident said that they had not been bathed for an extended period of time and as a result had developed areas of skin impairment.

Over a six-week timeframe the resident was bathed 5 out of 12 times scheduled.

Sources: interviews with the resident, a personal support worker (PSW), director of care (DOC) and the home's Administrator. Review of the resident's clinical records and unit bathing records.
[155]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident.

Rational and Summary

A resident sustained an injury when a PSW transferred them inappropriately and without proper assistive aides.

Sources: A resident's clinical records, Lift/Transfer/Positioning Techniques Policy Number NUR-II-24, interviews with the Social Services Coordinator and Administrator.
[155]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident received a skin assessment by a member of the registered staff upon return from hospital.

Rational and Summary

A resident returned from hospital. A skin assessment was not completed upon their return.

Sources: resident's clinical records, interview with the DOC.
[155]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that three residents received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

Three residents were identified as having areas of impaired skin integrity. The Registered staff took photos of the skin impairment; however, there was no assessment of the skin using the home's clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

The lack of assessment may have affected ongoing re-evaluation and follow up treatment of the resident's wounds.

Sources: Pictures of wounds from the miscellaneous tab in point click care, skin and

wound assessment, progress notes, and interview with the Director of Care and wound care lead. [729, 155, 532]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident was reassessed weekly by a member of the registered nursing staff.

Rationale and Summary
A resident had areas of skin impairments that required reassessment weekly.

There were no weekly reassessments of the skin impairments during a two week timeframe.

The DOC stated that the registered staff should have been completing reassessments of the skin impairment weekly using the progress note titled "Skin Note 1".

The resident was at risk of wound deterioration when the registered staff were not

reassessing their skin impairments weekly.

Sources: Progress notes, Skin and wound evaluations, Interview with the DOC
[729]

WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

The licensee failed to ensure that a resident was offered a minimum of three meals a day.

Rational and Summary:

A resident stated that they had missed meals because didn't go to the dining room. The resident was not provided their meal on three separate days as they did not attend the dining room.

The resident had a medical condition, and by not offering them three meals a day they are put at risk of having medical complications.

Sources: Interviews with the resident, Director of Care, Administrator, review of resident's clinical records, and the home's investigation notes.
[155]

WRITTEN NOTIFICATION: Housekeeping

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that cleaning and disinfection of contact surfaces was followed in accordance with evidenced based practices.

Rationale and Summary
Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, recommended when using disinfectant, there should be systems in place to ensure the efficacy of the disinfectant over time, such as reviewing the expiry date.

It was observed that multiple Viroban plus disinfectant wipes in the home had expired in 2022. The Accel Intervention disinfectant wipes the home was using had

also expired as of October 2023.

The DOC said that all the Viroban plus wipes and Accel Intervention/Virox wipes in the home had expired.

By using expired cleaning products in the home there was a potential risk of not effectively cleaning and disinfecting contact surfaces.

Sources: Observations of Care Area One and Two, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, interviews with the DOC and IPAC Lead. [155, 729]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to immediately inform the Director of the home's COVID-19 outbreak, which is a disease of public health significance as defined in the Health Protection and Promotion Act.

Rationale and Summary

Public Health Ontario declared a COVID-19 outbreak in the home. The home did not report to the after-hours action line or complete a critical incident (CI) report to inform the Director of the confirmed outbreak until twenty-four hours later.

The home's failure to immediately report the outbreak to the Director may have delayed follow-up by the Ministry of Long-Term Care.

Sources: Critical Incident Report, Interview with the IPAC lead and Administrator. [729]

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee failed to comply with FLTCA, 2021, s. 24 (1)

The licensee shall:
A) Implement the interventions outlined in the Specialized Geriatric Services consultation report, that specifically recommends implementing a sensor alarm before a residents room. The sensor alarm must activate when the residents door is open or closed and must meet the needs of both the hearing and hearing impaired staff and residents.

B) Develop, document and implement a plan to evaluate the the effectiveness of interventions put in place in part A) to ensure a residents safety when wandering into the vicinity of an identified residents room.

Grounds
The licensee failed to protect a resident from sexual abuse by another resident.

For the purpose of this Act and Regulation, "sexual abuse" means: any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A PSW witnessed a resident sexually abusing another resident. The PSW did not stop the abuse immediately and went to ask for assistance from the RN.

The home did not implement the recommendations by a consultant, nor implement the interventions outlined in the critical incident report.

Sources:
Review of the residents progress notes, Care plans, home's investigation notes.
Interview with a PSW, RN, and the home's Administrator.
[729]

This order must be complied with by February 21, 2024

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (2) (e)
Policy to promote zero tolerance
Contents
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 25 (2)(e)

The licensee shall:

A) Revise the home's Zero Tolerance of Abuse and Neglect of Residents policy to include a written process that provides direction to staff in the home, on call staff, and management on how to manage incidents of alleged, witnessed, or suspected sexual abuse. The process must include:

i) Direction on how and when to complete physical and emotional assessments of the residents involved and communicating the results of the assessments to the substitute decision maker, physician and authorities. The assessments should include the name of the assessment and where in the electronic chart they should be documented.

ii) When and how to intervene when an incident of sexual abuse is witnessed to ensure residents are protected from further abuse.

iii) Develop and implement a consent and capacity assessment based on best practices that would determine whether the sexual conduct between residents was consensual.

B) Ensure the agency RN and all other staff, including the management team and on call staff are provided education, on the home's revised Zero Tolerance of Abuse and Neglect of Residents policy.

C) Document the education, as outlined part A and B), including the date, format, staff attending the training, including the staff member who provided the education

Grounds
The licensee failed to comply with the home's policy to promote zero tolerance of abuse and neglect when there was witnessed sexual abuse of a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was to ensure that procedures for investigating and responding to witnessed abuse was complied with.

Specifically, staff did not comply with the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents" revised November 2022, which directed staff to complete a head to toe assessment, internal reporting forms, notify the substitute decision maker (SDM) immediately following the incident and complete an analysis and evaluation of the policy after the incident.

Rationale and Summary

A PSW witnessed a resident sexually abusing another resident. The PSW did not stop the abuse immediately and went to ask for assistance from the RN.

The RN separated the two residents. Nursing staff did not complete a physical assessment to determine the presence of any injury, nor did they complete vital signs or assess for pain or emotional impact. Furthermore, the Physician and the substitute decision maker (SDM) were not immediately contacted despite the resident being in distress and calling for help.

The home's policy titled "Zero Tolerance of Abuse and Neglect of Residents" revised November 2022", directed the clinical staff to:
i) Conduct a head-to-toe physical assessment for any alleged or actual physical abuse.
ii) If the abuse caused physical pain, injury, or distress to notify the SDM immediately.
iii) The staff member in charge was to ask the person that witnessed the abuse to complete the "Witness Report Form" and the charge nurse was to investigate and record the results of the investigation on the "internal reporting of abuse/neglect of a resident form".
iv) An analysis of every incident of abuse and neglect of a resident was to be undertaken promptly after becoming aware of it.
v) Offer information about resources to residents and families involved in the alleged incident such as social work counselling, pastoral care or the physician.

The home's Administrator and Physician were not aware that a physical assessment had not been completed until it was brought to their attention during the Ministry of Long-Term Care inspection.

The staff did not communicate accurate results of the assessment to the Physician, Police or the SDM. This may have delayed the immediate follow up by the physician to make a clinical decision in relation to the residents treatment and the polices' decision as to whether to conduct an investigation.

Sources: Review progress Notes, home's investigation notes, policy titled "Zero Tolerance of Abuse and Neglect of Residents" revised November 2022", head to toe assessments, interview of RN, Administrator and Physician.
[729]

This order must be complied with by February 21, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee failed to comply with O. Reg. 246/22, s. 102 (2)(b)

The licensee shall:
A) Document in the residents' plan of care that the additional precautions process is completed.

B) Revise the home's current IPAC audit tool to ensure that the home's stock supply of hand sanitizer, disinfectant and other PPE products are not expired and the stock is rotated. The process must include documentation to capture the name and expiry dates of the products used in the home. The audit is to include the person responsible to complete the audit, the date and time the audit was completed and corrective action taken if expired product is found. The audit is to be completed following the timelines set out in the Ministers Directive.

C) Re-educate a PSW on the proper use of N95 masks and disinfection of eye

protection when providing care for residents diagnosed with COVID-19. The education must be documented with the date of the education, person completing the education and a copy of the education must be kept in the home.

Grounds
The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

The home declared a Covid-19 outbreak that initially involved one resident. Twenty-four hours later an additional five residents had tested positive for Covid-19 and twelve days later the home had a total of twenty-eight residents test positive.

A) According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: Point-of-care signage indicating that enhanced IPAC control measures are in place and additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Three resident doors were observed to have a yellow PPE caddy that was stocked, however there was no point-of-care signage posted indicating that enhanced IPAC control measures were in place or the additional PPE requirements.

The IPAC lead said signage should have been posted on the door to the rooms.

When the home did not implement the use of signage for additional precautions, the lack of appropriate IPAC measures being followed may have contributed to the

spread of infection.

Sources: Observations of resident rooms, residents clinical records, Point Click Care home page Covid list, interview with IPAC lead.
[155, 729]

B) The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023 (IPAC Standard) section 9.1 (f) stated at minimum additional precautions shall include additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

i) It was observed that a resident was in isolation under droplet contact additional precautions. The resident was observed to be sitting at the entrance to their room, and coughing.

The dirty linen and laundry bin to doff soiled PPE was not located at the exit to their room but was placed across the room near the bathroom requiring staff to remove soiled PPE and walk through the room without protection to the hallway.

ii) A Personal Support Worker (PSW) entered the residents room wearing the required PPE and provided nourishment assistance. When the PSW doffed their PPE, they removed their gown and gloves and disposed of them in the dirty garbage bin that was located across the room from the exit.

The IPAC checklist for Long-Term Care and Retirement Homes published: September 2023, page 14 of 17 instructed the home to ensure that garbage and/or laundry bins were positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, and prior to exiting the room.

The IPAC Lead stated the dirty garbage and linen bin should be located just inside or outside the entrance to the residents' room.

There was risk to all residents in the home for transmission of microorganisms when placement of dirty garbage and linen bins to doff PPE was not placed at the exit to residents' rooms that required additional precautions.

Sources: Review of document titled: The IPAC checklist for Long-Term Care and Retirement Homes published: September 2023, page 14/17, IPAC standard revised September 2023, Observations during the inspection, interview with IPAC Lead. [729]

C) The IPAC Standard for LTCHs, revised in September 2023, section 5.3 (h), indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to cleaning and disinfection.

A PSW was providing nourishment assistance to a resident in their room and was in isolation for a diagnosis of Covid-19. The PSW removed their gown and gloves, and completed hand hygiene when they exited the room, they did not change their N95 mask or disinfect their face shield.

The PSW stated that they were to disinfect their face shield when exiting a room of a resident that was covid-19 positive.

The home's IPAC lead stated that after interacting with covid-19 positive residents, the staff were to change their N95 masks and sanitize their face shields. They stated that they have had many discussions with staff and would need to re-educate them.

Sources: Observations of a PSW in a residents' room, interview with a PSW and the home's IPAC lead.
[729]

D) The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023 (IPAC Standard) section 10.1 states the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

The home's hand sanitizer manufactured by clean works was in dispensers in the hallways of resident care and general areas contained hand sanitizer that was expired. The home had additional expired hand sanitizer in their housekeeping and maintenance rooms.

The home's Public Health consultant (PHC) #120 stated that expired hand sanitizer product should be replaced.

By using expired hand sanitizer in the home may have caused the spread of infection when staff, residents and visitors were using expired hand sanitizer to clean their hands.

Sources: Observations during the inspection, Interview with IPAC Lead and PHC, review of expiry dates of Clean Works hand sanitizer.
[729]

This order must be complied with by February 21, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP 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, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.