Ontario

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

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

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

Public Report

Report Issue Date: January 10, 2025
Inspection Number: 2025-1450-0001
Inspection Type: Critical Incident
Licensee: The Ontario Mission of the Deaf
Long Term Care Home and City: Bob Rumball Home for The Deaf, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 6-10, 2025

The following Critical Incident (CI) intakes were inspected:

- Intake #00128665, #00128787, and #00131690, related to resident to resident abuse
- Intake #00132188, related to staff to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that interventions provided for three residents were documented in their plans of care. Gaps in the documentation increased the risk that staff may not provide the interventions as required.

Sources: observations, residents' plans of care, and interviews with a resident and staff.

Date Remedy Implemented: January 9, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (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 licensee has failed to ensure that the additional requirement under section 7.3 (b) of the Infection Prevention and Control (IPAC) Standard issued by the Director

was followed.

Specifically, the licensee has failed to ensure that audits were performed regularly to ensure that all staff could perform the IPAC skills required of their role, when their Hand Hygiene and Personal Protective Equipment (PPE) audits did not include the names of all staff audited.

Sources: the home's hand hygiene and PPE audits, IPAC Standard (2023) and an interview with the IPAC Lead.

Date Remedy Implemented: January 6, 2025

WRITTEN NOTIFICATION: Prevention of abuse and neglect.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure a resident was protected from abuse by a staff. Following an interaction with a staff, the resident was upset and felt uncomfortable with the staff providing care for them.

Sources: a critical incident report, the home's investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident was displaying responsive behaviours, strategies that were developed to manage these behaviours were implemented, which resulted in an escalation of the resident's responsive behaviours and an incident.

Sources: a resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to ensure that two residents' interventions related to responsive behaviours were documented. By not documenting the interventions provided, an analysis and an assessment of the residents' responsive behaviours were not completed, and appropriate interventions could not be identified and implemented if required.

Sources: a critical incident report, residents' clinical records, the home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that a resident's interventions to minimize the risk of altercations and potentially harmful interactions between and amongst residents were implemented. Subsequently, the resident's responsive behaviour escalated and resulted in an altercation with another resident.

Sources: a critical incident report, residents' clinical records and interviews with staff.