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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
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Original Public Report

Report Issue Date July 5, 2022
Inspection Number 2022_1450_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Ontario Mission of the Deaf, North York

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

Lead Inspector
Tracy Muchmaker #690

Inspector Digital Signature
Tracy L Muchmaker
Digitally signed by Tracy L Muchmaker
Date: 2022.07.05 11:20:11 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 6-10, 2022.

The following intake(s) were inspected:

- One intake, related to a fall that resulted in an injury;
- One intake, which was a complaint related to skin and wound care.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Skin and Wound Prevention and Management

Inspector #741150 observed this inspection.

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

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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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident, that sets out clear directions to staff and others who provided direct care to the resident related to falls prevention.

A resident's plan of care indicated that the resident utilized a Personal Assistance Service Device (PASD) to decrease their fall risk. The resident was observed at a specified time during the inspection, and the PASD was not in place.

A Personal Support Worker (PSW), and a Registered Practical Nurse (RPN), indicated that the PASD was no longer in use at the specified time, and the direction in the plan of care was not clear as to when it was to be in place.

The Director of Care (DOC) verified that the PASD was only to be utilized at specified times, and the care plan did not provide clear direction to staff. After speaking with the DOC, the resident's care plan was revised to indicate when the PASD was to be in place.

Sources: A resident's plan of care; Inspector #690's observations; interviews with PSW staff, registered staff, and the DOC.

Date Remedy Implemented: June 10, 2022 [#690]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA 2021 s. 6 (10) (c)

The licensee has failed to ensure that a resident's falls interventions were revised in their plan of care when their care needs changed.

1. A resident's plan of care indicated that a falls prevention intervention was to be in place. The resident was observed, and the falls prevention intervention was not in place.

A PSW, and RPN, both verified that the intervention was no longer in place. The RPN, indicated that the intervention should have been removed from the plan of care. The DOC verified that if the intervention was no longer utilized, then it should have been resolved from the plan of care.

After speaking with the DOC, resident #001's care plan was revised, and the intervention was removed from the plan of care.

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Sources: A resident's plan of care; Inspector #690's observations; interviews with a PSW, RPN, and the DOC.

Date Remedy Implemented: June 10, 2022 [#690].

2. A resident's care plan indicated that the resident was to have a specified device in place, at specified times.

During observations of the resident, the resident did not have device in place at the specified time. An RPN indicated that the resident was no longer required to utilize the device at that specified time, and that the care plan had not been revised to reflect this.

After speaking with the DOC, the care plan was revised to reflect the current direction.

Sources: Sources: A resident's plan of care and progress notes; Inspector #690's observations; interviews with a PSW, RPN, and the DOC.

Date Remedy Implemented: June 10, 2022 [#690]