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

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: April 4, 2024
Original Report Issue Date: March 13, 2024
Inspection Number: 2024-1450-0001 (A2)
Inspection Type: Complaint Critical Incident Follow-up
Licensee: The Ontario Mission of the Deaf
Long Term Care Home and City: Bob Rumball Home for The Deaf, Barrie

Amended By	**Inspector who Amended Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.04.05 08:16:34 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance due date for CO #001 extended to May 31, 2024.

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

Amended Public Report (A2)

Amended Report Issue Date: April 4, 2024
Original Report Issue Date: March 13, 2024
Inspection Number: 2024-1450-0001 (A2)
Inspection Type: Complaint Critical Incident Follow-up
Licensee: The Ontario Mission of the Deaf
Long Term Care Home and City: Bob Rumball Home for The Deaf, Barrie

Lead Inspector	**Additional Inspector(s)**
Kim Byberg (729)	Sharon Perry (155) Dianne Tone (000686)
Amended By Kim Byberg (729)	**Inspector who Amended Digital Signature** Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.04.05 08:17:07 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Compliance due date for CO #001 extended to May 31, 2024.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 21-23, 26-29 and March 4, 2024.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:
- 00100810, and 00101456, related to allegations of abuse

The following intake(s) were inspected in this Complaint Inspection:
- 00101520, and 00104617, related to allegations of abuse between residents
- 00108626, related to an allegation of improper care towards a resident

The following intake(s) were inspected in this Follow-Up Inspection:
- 00106144 CO #001
- 00106145 CO #002
- 00106146 CO #003

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1450-0004 related to FLTCA, 2021, s. 25 (2) (e) inspected by Kim Byberg (729)

Order #003 from Inspection #2023-1450-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Kim Byberg (729)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1450-0004 related to FLTCA, 2021, s. 24 (1) inspected by Kim Byberg (729)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of Licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023_1450_0004 served on January 9, 2024, with a compliance due date of February 21, 2024.

The licensee failed to ensure that a door sensor alarm was installed near a resident's room that activated when the resident's door was open or closed and met the needs of both the hearing and hearing impaired staff and residents.

Rational and Summary
A door sensor alarm was installed. The door sensor alarm only activated when the door went from a closed position to an open position.

The installation of the specific alarm had not been completed prior to the follow-up.

The home did not re-evaluate the behavioural interventions as specified in part b) of the compliance order until five days after the compliance due date.

Sources: Observations during inspection of a residents' door in the open position, review of emails from the home, documentation review of thirty minute checks of the resident, interview with the home's Physician and the Administrator.
[729]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Inspection #2024_1450_0004 CO #001 Duty to Protect. Report Date January 9, 2024. CDD February 21, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 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 failed to ensure that two residents had strategies implemented to respond to their behaviours.

Rational and Summary:

A) A Residents' plan of care identified that they had responsive behaviours and required staff to implement specific interventions.

It was observed that staff did not implement the specific interventions but documented they had.

By staff not implementing the specific interventions there was a risk that the resident could wander into other residents' rooms and personal space putting the resident and others at risk.

Sources: review of the residents' clinical records, interviews with PSW's, and the DOC, observations done during the inspection.
[155]

B) A different residents' plan of care stated that they became agitated if a co-resident wandered into their space or room. An intervention listed on the residents' plan of care was to ensure that when they were in their room, their door was to be closed with the stop sign across the door.

It was observed that staff did not implement the specific interventions outlined in their plan of care.

By not implementing the responsive behavior strategies for the resident there was a risk to both residents if the co-resident wandered into the other residents personal space.

Sources: review of residents' clinical records, interviews with PSW's, and the DOC, observations done during the inspection
[155]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 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 failed to ensure that actions were taken to respond to the needs of a residents' responsive behaviours, including reassessments and that the resident's responses to interventions were documented.

Rational and Summary

A Resident was noted to have specific behaviors.

There were multiple incidents where the resident was exhibiting these behaviours

and the interventions in place were not successful. Other residents expressed frustration towards the resident and showed physical responsive behaviours towards the resident as a result.

Multiple psw's shared that the interventions that were in place were not always effective as they could not be always with them as they have other residents to care for.

By the resident not having interventions of behaviours documented and no reassessment done when interventions were documented as ineffective put the resident at risk as they continued to express the same behaviours without effective interventions.

Sources: Residents' clinical records, observations done during the inspection, interviews with PSW's, Social Services Manager/Behaviour Support Services Lead, Administrator and other staff.
[155]

WRITTEN NOTIFICATION: Recreational and social activities program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)
Recreational and social activities program
s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;

The licensee failed to ensure that the program included the development, implementation and communication to all residents and families of a schedule of recreation and social activities that were offered during evenings.

Rational and Summary:

Review of the programs calendar for three months showed that there were no activity programs scheduled after 1500 hours.

The Social Services Manager shared that the Programs and Social Services Coordinator work from 0800 to 1600 hours. They shared that evening programs in the past were not successful but if the residents ask to do something in the evening they will accommodate it.

There are no scheduled evening recreation and social activities on a regular basis.

Sources: review of Programs Coordinator and Social Services schedules, review of Programs Calendars; interviews with a PSW, Social Services Manager and other staff.
[155]

COMPLIANCE ORDER CO #001 Duty to protect

NC #005 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) Re-educate all registered staff, including agency registered staff on the home's pain management program.
The education must include:
i) when to complete a PAINAD assessment and when to complete the home's assessment titled "Pain Assessment 2";
ii) what pain level scores mean to determine a residents pain and the effectiveness of pain management strategies;
iii) when to complete follow-up pain assessments for both routine analgesic and PRN analgesic administration;
iv) when to administer additional pain management strategies when routine or PRN analgesic was not effective.

B) Develop and implement an audit tool to ensure residents that experience pain are provided pain management strategies and that their pain is re-evaluated to ensure the strategies have been effective. The audit tool must include documentation to capture the name of the resident, pain scores, pain intervention, re-evaluation intervention, time re-evaluation occurred and effects of pain management strategies. The audit is to include the person responsible to complete the audit, the date and time the audit was completed and corrective action if deficiencies determined. The audit must be completed daily for at minimum of one month or until compliance is obtained.

C) Educate all registered staff including agency staff, on what a physical assessment post fall is to include when an injury is suspected.

D) Develop, implement, and educate all registered staff including agency staff on the home's process that directs registered staff to complete diagnostic testing requisitions. The process must include how to complete the requisition in full, names and location of clinics utilized by the home and telephone numbers of the clinics to call for diagnostic results and when to call or obtain diagnostic testing results.

E) Provide communication to all residents, families, care givers, Power of Attorney's (POA) and Substitute Decision Makers (SDM) on the home's expectations when it comes to taking residents for diagnostic testing and appointments in relation to an acute injury. The communication must include responsibilities for arranging or providing transportation, costs, and communication of information coming out of those appointments/tests.

F) Document the education and communication, as outlined in part A, C), D) and E), including the date, format, staff attending the training, families (POA, SDM, caregivers) receiving the communication the staff member who provided the education/communication. The education and communication records must be available and kept in the home.

Grounds
The licensee failed to ensure that a resident was not neglected by staff when they experienced pain from a and had a delay in treatment.

For the purpose of this Act and Regulation, “neglect” means the failure to provide a

resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

An incident occurred that caused significant pain and other adverse effects for a resident. The resident was not provided any additional pain management interventions beyond their regular scheduled analgesic. The scheduled analgesic was administered over fourteen hours after the incident despite follow up of moderate to high pain levels at multiple intervals within the fourteen hours. The resident continued to express pain for several days after the incident despite routine analgesic being provided and no other interventions.

Initial written communication to the Physician at the time of the incident was not accurate. The Physician was not contacted for additional assessment or treatment at the time of the incident despite increased pain and additional concerns.

A physician was contacted two days later at which time diagnostic testing was ordered. The resident did not receive their prescribed test for four days after the order was obtained. The diagnostic test results were not obtained for another six days and no follow up was completed by the home as to the results, despite the resident having pain and clinical signs of injury. The diagnostic test results showed an injury that required treatment and follow up by a physician.

The resident was negatively impacted when they had prolonged pain without additional pain management interventions, lack of communication with the physician and lack of follow up for results of the diagnostic test when the resident had unmanaged pain and significant injury.

Sources: Review of residents progress notes, PAINAD and pain assessments, electronic medical record (eMAR), diagnostic test results, interview with Registered Nurse's (RN), and, RPN's, Physician and DOC.
[729]

This order must be complied with by May 31, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #001 - Duty to Protect, inspection #2023_1450_0004, Report date January 9, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.