Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2021	2021_815623_0005	016886-20, 020918-20, 022242-20, 022343-20	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

Springdale Country Manor
2698 Clifford Line, R.R. #5 Peterborough ON K9J 6X6

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

SARAH GILLIS (623), DENISE BROWN (626)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 2-4, 2021 onsite February 5, 2021 offsite

The following intakes were inspected:
Log #016886-20 for Critical Incident Report for an allegation of abuse.
Log #020918-20 for Critical Incident Report for a fall with a fracture.
Log #022242-20 for Critical Incident Report for a fracture of unknown cause.
Log #022343-20 for Critical Incident Report for a fall with a fracture.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers and residents.

The Inspectors also reviewed the licensee's internal records, resident health care records, applicable policies, observed the delivery of resident care and services, including staff to
resident interactions. Observations of Infection Prevention and Control practices were also conducted throughout this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #006 sets out the planned care for the resident, as there was no intervention regarding footwear in the resident's plan of care.

Critical Incident Report was inspected related to resident #006's fall that occurred on an identified date. The resident had sustained a fall and neither the progress note or the post-fall assessment record, titled "Post Fall Investigation" indicated, if the resident was wearing appropriate footwear at the time of the fall. The resident experienced another fall and no information regarding footwear was found on that Post Fall Investigation record. The progress note documentation for the initial fall, indicated that the resident's feet were swollen, and the physician was notified. Another progress note entry on the same date indicated that the resident did not have shoes as result of the edema and the resident's family member was informed. The resident also fell on a third occassion, the Post Fall Investigation record indicated, that the resident was "barefoot" at the time of the fall, but there was no notation found in the progress note.

Registered Nurse #112 indicated that the resident was not wearing shoes at the time of the fall on an identified date. Registered Nurse #112 and PSW #111, both indicated that the resident's feet were swollen, and the family provided looser slippers to fit the resident's feet. In a review of resident #006 plan of care, there was no intervention regarding footwear found. The DOC indicated that all care interventions should be documented in the plan of care. Not documenting all the fall prevention interventions such as the resident's use of appropriate footwear could place the resident at increased risk for falls.

The licensee failed to ensure that resident #006's plan of care set out the planned care in reference to the intervention related to footwear.

Sources: CIR related resident #006, the health records and Post-Fall Investigations. The Falls Prevention and Fall Management policy: OTP-OPFP-8.6, effective date May 2017. Interviews with PSW #111, RN #112 and the DOC. [s. 6. (1) (a)]

2. The licensee failed to ensure that the written plan of care sets out the planned care for the resident #005, as the personal alarm were not noted in the plan of care.

A Critical Incident Report was inspected related to resident #005's fall on a specified

date. On review of the resident's health records, it was determined that resident #005 had sustained a several falls during a specified period of time. Registered Nurse #112 and PSW #109, both indicated that the resident had a personal alarm that was used. On review of the resident's plan of care, the resident's personal alarm was not noted as an intervention in the plan of care. The DOC indicated that all care interventions should be documented in the plan of care. Not documenting all the fall prevention interventions in plan of care could diminish staff awareness and increase the resident's risk of falls.

The licensee failed to ensure that resident #005's personal alarm was included as an intervention in the resident's plan of care.

Sources: CIR related resident #005, the health records and Post-Fall Investigations. The Falls Prevention and Fall Management policy: OTP-OPFP-8.6, effective date May 2017. Interviews with PSW #109, RN #112 and the DOC. [s. 6. (1) (a)]

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 by ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident #005, #006 and #008 fell, and post-

fall assessments were conducted using a clinically appropriate assessment instrument specifically designed for falls, that the post-fall assessment documents were not fully completed.

A review of the licensee's Falls Prevention and Fall Management policy: OTP-OPFP-8.6, effective date May 2017, direct that the post-fall assessment shall be completed within twenty four hours of the fall and provided to the Director of care (DOC) for review on the electronic record.

A Critical Incident Report (CIR) was inspected related to resident #005's fall on an identified date. On review of the resident's health records, it was determined that resident #005 had sustained several falls during a specified period of time. The review of the health records further indicated, that the post-fall assessment records titled, "Post Fall Investigation" documentation were incomplete, as there were blank sections observed on the records. There was no post-fall assessment conducted after resident #005's fall on an identified date. A CIR was also inspected related to resident #006's fall that occurred on an identified date. On review of resident #006's health records by Inspector #626, it was determined that the resident had sustained several falls, over two months. Further review of the resident's health records indicated that the post-fall assessment records documentation were incomplete, as there were blank sections observed on the records. The resident sample was expanded as non-compliance was found to include resident #008, the resident sustained a fall on an identified date. In reviewing resident #008's health records, it was determined that the post-fall assessment documentation was incomplete, as there were blank sections observed on the record. Inspector #626 was unable to observe resident #005, #006 and #008 as the residents were not present at the time of the inspection. Failure to complete the post-fall assessment records could place the residents at increased risk for future falls.

In separate interviews RN #112 and RPN #103 indicated, that the post-fall assessment document must be fully completed. The DOC indicated becoming aware that the post-fall assessments were not fully completed during the inspection, and they should have been. The DOC also indicated that post-fall assessments are completed and documented by an RN or RPN at the time of the fall. In another interview the DOC confirmed that a post-fall assessment was not completed after resident #005 sustained a fall.

The licensee has failed to ensure that residents #005, #006 and #008's post-fall assessment records documentation were not fully completed as required under the falls program, that when a resident has fallen, the resident is assessed using a clinically

appropriate assessment instrument that is specifically designed for falls. The licensee's Falls Prevention and Falls Management policy: OTP-OPFP-8.6 effective date May 2017 further supports, that after a resident has fallen, a post-fall assessment must be completed and reviewed by the DOC.

Source: CIS related to resident #005, the health records and Post-Fall Investigations; CIS related to resident #006, the health records and Post-Fall Investigations; Resident #008's health records and Post-Fall Investigation. The Falls Prevention and Falls Management policy: OTP-OPFP-8.6, effective date May 2017 and interviews with, RN #112, RPN #103 and the DOC. [s. 49. (2)]

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 by ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that Personal Support Worker (PSW) #100, #101 and #102, Registered Practical Nurse (RPN) #114 participated in the implementation of the

Infection Prevention and Control (IPAC) program related to the use of personal protective equipment (PPE) and hand hygiene.

During the inspection PSW #101 was observed in resident #001's bedroom, who required droplet and contact precautions as per the sign on their bedroom door. The PSW was wearing a mask, gloves, gown but no eye protection when they were assisting the resident to eat their meal. The isolation caddy outside of resident #001's bedroom did not contain goggles or masks. PSW #100 was observed entering resident #002's bedroom, who required contact precautions as per the sign on their bedroom door. The PSW was observed to not clean their hands before donning gloves to enter the resident's room. When interviewed, PSW #100 indicated to the Inspector that they had forgotten to sanitize their hands but were aware that they should have. PSW #102 was observed in resident #003's bedroom, who was identified by a sign on the bedroom door, to require contact precautions. There was no hand sanitizer immediately available outside of resident #003's bedroom. PSW #102 was not wearing PPE and did not sanitize their hands upon exit. RPN #103 was observed standing in the medication room with the door open, their mask on their chin and eating their lunch on the top of the medication cart.

The Director of Care (DOC) indicated that the expectation is that all staff participate in the IPAC program including wearing the proper PPE for identified isolation rooms as well as follow the Just Clean Your Hands (JCYH) program for the four moments of hand hygiene. The long-term care home's IPAC program included requirements for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident on contact and droplet precautions and a gown and gloves for all contact with a resident on contact precautions. Upon exiting the isolation room all PPE is to be removed and a new mask is to be applied. All staff are required to monitor the PPE caddy to ensure that the necessary equipment is readily available at the entrance to the resident room where isolation precautions were identified. All staff are required to follow the Best Practice for donning and doffing of PPE as well as the mandatory masking protocol in Directive #3.

PSW #100, #101, #102 and RPN #103 failed to participate in the implementation of the IPAC program which presented actual risk of infection to resident #001, #002, and #003, and potential risk to all other residents and staff in the home.

Sources: Observations of PSW #100, #101, #102 and RPN #103, interviews with the DOC and PSW #101, signage on resident #001. #002 and #003's bedroom door, IPAC best practice and JCYH LTCH Implementation Guide. [s. 229. (4)]

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 by ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 25th day of February, 2021

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

Original report signed by the inspector.