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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Mar 8, 2022	2022_946111_0002	014794-21, 016630-21, 017257-21, 001216-22, 001441-22	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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 1 to 4, 7, 2022

The following critical incidents were inspected concurrently during this inspection:
-Three critical incidents related to resident to resident physical abuse.
-Two critical incidents related to falls with injury for which the resident's were transferred to hospital.

In addition, a complaint was inspected concurrently during this inspection related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT) and residents.

During the course of the inspection, the inspector(s): observed residents, reviewed resident health records, home's investigations, reviewed the following home's policies: Falls Prevention Management, Prevention of Abuse and Neglect and Responsive Behaviour Management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that resident #002 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, and different approaches had been considered in the revision of the plan of care related to falls.

Resident #002 was a risk for falls due to a number of factors. During a specified period, the resident sustained a number of falls. A number of the falls occurred as a result of an altercation with another resident, due to demonstrated responsive behaviours and resulted in the resident sustaining injuries to specified areas. A number of the falls resulted in injuries, one with a serious injury requiring transfer to hospital. The use of a mobility aid and alarming devices was implemented upon their return from hospital. The resident sustained additional falls from their mobility aid and one that resulted in an injury for which they were transferred to hospital. Upon return from hospital, the resident was placed on increased monitoring. Resident #002 was observed by the Inspector and there was no increased monitoring in place. The staff documented that a specified falls prevention intervention was not available for use and other falls prevention interventions were not used due to increased risk to the resident, despite never being trialled. The PT confirmed one of the falls prevention interventions were never trialled. An RN indicated another falls prevention intervention was never trialled due to risk to the resident, despite documentation indicating none was available. Failing to revise the plan of care for resident #002 when the care set out in the plan had not been effective, and different approaches considered, resulted in the resident sustaining ongoing falls with injuries.

Sources: CI,health care record for resident #002, observations of resident #002, falls prevention meeting minutes and interview of staff.

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 to ensure when a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, 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 :

The licensee has failed to ensure that when resident #002 had fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #002 had sustained a number of falls during a specified period. An RN indicated the registered staff were expected to complete the post fall investigation after each fall and was the home's clinically appropriate assessment instrument. There were no post fall assessments completed for a number of the falls. Failing to complete post fall assessments can lead to contributing factors and possible strategies to reduce future falls not being considered, and the resident continued to fall.

Sources: health record of resident #002, post fall investigations for resident #002 and interview of staff.

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 to 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that strategies had been developed and implemented to respond to resident #001 who demonstrated responsive behaviours, where possible.

Resident #001 demonstrated specified ongoing responsive behaviours and was difficult with redirection. The resident had demonstrated these responsive behaviours towards resident # 011 and #012, on more than one occasion and resident #011 expressed fear of resident #001.

On a number of dates, resident #001 was found demonstrating responsive behaviours towards resident #002 (room mate), with some of the incidents resulting in an injury to resident #002 or impacting the residents rights to live in a safe and secure environment. One incident involved abuse by resident #001 towards resident #002. On another specified date, resident #001 was witnessed demonstrating the same responsive behaviour towards resident #003, that resulted in an altercation and resident #001 sustaining an injury. There were a number of prior incidents involving resident #001 and #003 when abuse should have been suspected and resulted in resident #001 sustaining an injury. Resident #005 reported that resident #001was continuously demonstrating the specified responsive behaviour and one of the interventions put in place to prevent a recurrence was not effective. A number of staff all confirmed that resident #001 was demonstrating the specified responsive behaviour ongoing, and at specified times, one of the interventions used did not respect resident #002's rights and was inappropriate. There were a number of strategies developed for resident #001 and some of the strategies were either not in place, not implemented or inappropriate. Failing to ensure that there were strategies developed and implemented for resident #001’s ongoing responsive behaviours placed several residents at risk for injury, not being able to be in a safe and secure environment or caused them to be fearful of the resident, and resident #002 was a recipient of resident #001’s responsive behaviours for a number of months before additional strategies were considered.

Sources: two CIS, health record of resident #001, observations of resident #001, #002, #003 and interviews of resident #005 and staff.

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 to ensure that, for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible; and (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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the outcome or current status of the individual or individuals who were involved in the incident.

A PSW witnessed resident #004 being abusive towards resident #005 in a specified area and there was no indication whether resident #004 had sustained any pain or injury as a result of the incident. A number of months later and as a result of the inspection, the home updated the report to the Director and indicated the resident had not sustained any pain or injury as a result of the incident. Review of the home's investigation indicated resident #005 had complained of pain and had sustained an injury to a specified area, as a result of the incident. Resident #005 also confirmed to the Inspector that they had pain and an injury following the incident. The DOC confirmed the report to the Director was updated with the outcome and status of the resident as a result of the inspection and was unaware that resident #005 had sustained an injury and pain following the incident.

Source: CIS, resident #004 and #005 health records, interview of resident #005, home's investigation and interview of staff.

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 to ensure In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A PSW witnessed resident #004 being abusive towards resident #005 in a specified area. There was no indication either resident's SDMs were notified of the outcome of the home's investigation until a number of months later. The DOC confirmed the home had completed their investigation the day after the incident had occurred and had not updated the family of the result of the investigation.

Sources: CIS, resident #004 and #005 health records, interview of resident #005, home's investigation and interview of staff.

Issued on this 10th day of March, 2022

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

Original report signed by the inspector.