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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: April 12, 2023	
Inspection Number: 2023-1069-0001	
Inspection Type: Critical Incident System	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Springdale Country Manor, Peterborough	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature** Lynda Brown Digitally signed by Lynda Brown Date: 2023.04.28 10:36:31 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 15, 16, 17, 20, 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00001168 - related to a fall with injury for which the resident was taken to hospital.
- Intake: #00003961 , #00005351, #00006337, #00015995, #00018199 and #00083833 - related to an alleged resident to resident abuse.

The following intake(s) were completed during this inspection:

- Intake #00007843 - related to a fall with injury for which the resident was taken to hospital.
- Intake #00018386- related to responsive behaviours.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed to ensure that when a resident was reassessed, and the plan of care reviewed, the plan was revised when the care set out in the plan had not been effective related to falls.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director for a fall with injury to a specified area, for which the resident was transferred to hospital. Following the fall, the resident then had a number of falls over a period of months. All the falls occurred at a specified area and occurred because of the resident attempting to self transfer. One of the interventions in place at the time of the falls was known to be ineffective. After a number of falls, the family requested a Personal Assistance Services Device (PASD) be implemented to prevent further falls. The PASD assessment was not completed until a number of months later. There was no documented evidence when the PASD was actually implemented. Observation of the resident on various dates and times indicated, the PASD had been implemented. A Registered Nurse (RN) indicated the PASD had been implemented a number of weeks prior to the PASD assessment being completed.

Failing to revise the plan when it was determined not to be effective for a resident, resulted in the resident continuing to fall and sustain injuries.

Sources: CI, a resident's health record, PASD assessments, observations of a resident and interview of registered staff.
[111]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

1)The licensee failed to ensure they immediately completed an investigation into an alleged resident to

resident abuse incident.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident. A resident was witnessed being abusive towards another resident by the resident's roommate. The resident sustained an injury, was transferred to hospital and subsequently passed away. The home's policy for zero tolerance of abuse for investigating abuse, indicated the investigation was to be conducted using specified investigation procedures. There was no documented evidence the home completed the investigation according to their policy. The Administrator confirmed they did not complete the investigation as per the home's policy and concluded the allegation as unfounded. The health record of one of the residents involved in the allegation verified the allegation was founded.

Failing to ensure an immediate investigation was completed, as indicated in the home's policy, resulted in the home not concluding the investigation accurately.

Sources: CI, health record of two residents, home's investigation notes, Zero Tolerance of Abuse and Neglect of Residents Policy, Investigation Procedures Policy and interview of the Administrator.
[111]

2) The licensee failed to ensure they immediately completed an investigation into an alleged resident to resident abuse incident.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse involving two different residents. A resident reported to the Registered Practical Nurse (RPN) that another resident had been abusive towards them and resulted in an injury to a specified area. An RN had documented awareness of the incident a number of hours earlier and that the resident had sustained an injury. The Director of Care (DOC) confirmed there was no investigation available. The DOC was unaware that an RN had responded to the incident at the time it occurred, had not documented the incident until a number of hours later and did not report the incident.

Failing to ensure an alleged resident to resident abuse incident was immediately investigated, resulted in no awareness or no actions being taken regarding late reporting by an RN.

Sources: CI, health record of two residents and interview of the DOC.
[111]

3) The licensee failed to ensure they immediately completed an investigation into an alleged resident to resident physical abuse incident involving two residents.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse. A resident reported that they had been abuse in a specified area by another resident. The resident sustained an injury to a specified area as a result. There was no documented investigation provided. The DOC confirmed the alleged abuse was founded and they had no documented investigation.

Failing to ensure an alleged resident to resident abuse incident was immediately investigated, results in delay of actions being taken to prevent a recurrence.

Sources: CI, health record of two residents, interview of one resident and the DOC.
[111]

4) The licensee failed to ensure they immediately completed an investigation into an alleged resident to resident abuse incident.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse. A resident had been abusive towards another resident after they entered their room. The CI indicated the outcome, analysis and follow up would be completed upon further investigation. There was no documented evidence of an investigation completed for the incident. The DOC confirmed there was no investigation available.

Failing to ensure an alleged resident to resident abuse incident was immediately investigated, resulted in delay of actions being taken to prevent a recurrence.

Sources: CI, health record of two residents and interview of the DOC.
[111]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to ensure the Director was notified of the results of the investigation for an alleged resident to resident abuse.

Rationale and Summary

A CI was submitted to the Director for a resident to resident abuse incident. There was no documented evidence the Director was notified of the results of the investigation immediately upon completion. The Administrator confirmed the home's investigation had been completed on a specified date and the report to the Director had not been amended to include the results.

Failing to notify the Director of the results of an investigation into alleged resident to resident abuse resulted in the investigation being incomplete and inaccurate.

Sources: CI, health record of two residents, home investigation notes, staff schedules and interviews of the Administrator.
[111]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident, that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse. The CI indicated a resident reported to an RPN, an allegation of abuse by another resident that resulted in an injury and the incident had occurred a number of hours earlier. Documentation for one of the residents indicated an RN responded to the incident at the time of the occurrence, was aware of the injury and did not report the incident to the Director at that time. There was no documented evidence the Director was notified until a number of hours later when the RPN was notified. The RPPN confirmed they had not been notified of the incident prior to the resident reporting the incident to them. The RN could not recall who they notified. The DOC confirmed the Director was notified a number of hours after the incident occurred, after they became aware of the incident by the RPN.

Failing to ensure the Director is immediately notified of alleged resident to resident led to the home not immediately investigating the allegation.

Sources: CI, health record of two residents, interview with a resident, home's investigation notes and interviews with registered staff and the DOC.
[111]

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 3. i.

The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living was included in the resident's plan of care only if the use of the PASD was approved.

Rationale and Summary

A CI was submitted to the Director for a fall with injury for which a resident was transferred to hospital. The resident had sustained a fall with injury and was transferred to hospital for treatment. The resident had a number of additional falls over a number of months. All the falls occurred at a specified area while attempting to self-transfer. A number of the falls resulted in alteration in skin condition. After the resident had experienced a number of falls, the family requested and consented to a PASD to prevent further falls. There was no documented evidence of approval for the use of the PASD. Observation of the resident on various dates and times indicated, the PASD was in use. An RN indicated the PASD had been implemented for the resident for a number of months and confirmed there was no approval in place for the PASD.

Failing to ensure there is approval in place related to the use of a PASD for a resident resulted in a PASD being used for number of months without approval.

Sources: CI, health record of a resident, PASD assessments, observations of a resident and interview of registered staff.
[111]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (b)

The licensee failed to ensure that the written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to deal with persons who have abused or allegedly abused residents, when the abuse was by another resident.

Rationale and Summary

The home's zero tolerance of abuse and neglect of resident's policy did not contain procedures or interventions on how to respond when the abuse of a resident was by another resident or measures and strategies to prevent the abuse. The DOC and Administrator each confirmed the identified policy was the only policy related to zero tolerance of abuse and neglect of residents.

Failing to ensure the home's policy had procedures or interventions on how to respond when the abuse was by another resident or strategies to prevent the abuse, results in staff being unaware of actions to take when the resident abuse involves another resident.

Sources: Multiple CI's, Zero Tolerance of Abuse and Neglect of Residents Policy and interviews of Administrator and DOC.
[111]

WRITTEN NOTIFICATION: Notification re incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee failed to ensure the Substitute Decision Maker (SDM) of two residents were immediately notified of alleged resident to resident abuse.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident that had occurred a number of hours earlier. An RPN indicated a resident had reported they had been abused by another resident a number of hours earlier and reported the allegation to the SDM at that time. An RN documented they responded to the incident at the time of the occurrence and was aware the resident had sustained an injury but there was no documented evidence the SDM of either resident had been notified. The resident who sustained the injury indicated to the Inspector that they were still fearful of the other resident and was also upset at the time of the incident. The DOC confirmed the SDMs of both residents were notified of the allegation after the RPN became aware of the allegation, a number of

hours later.

Failing to immediately notify the SDM of two residents of an alleged resident to resident abuse results in a loss of trust from families towards the home.

Sources: CI, health record of two residents, home's investigation notes and interview of the DOC.
[111]

WRITTEN NOTIFICATION: Police notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee failed to ensure the appropriate police force was immediately notified of an alleged incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident. A resident had sustained an injury by another resident and was transferred to hospital as a result. The resident died a number of days later. The documentation revealed the SDM had contacted the police. The Administrator confirmed they did not contact the police.

Failing to immediately notify the police of an alleged resident to resident abuse resulted in the SDM of one of the residents contacting the police.

Sources: CI, health record of two residents, home's investigation notes, and interview of the Administrator.
[111]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

The licensee failed to ensure the names of all the staff who were present or responded to an incident of alleged resident to resident abuse, were included in the report to the Director.

Rationale and Summary

A CI was submitted to the Director for a resident to resident abuse incident. The CI only identified an RN as responding to the incident. There were a number of RPNs and PSWs that were also working when the incident occurred. The Administrator indicated they completed the report to the Director and confirmed that all staff who were present or responded to the incident, were not identified in the report to the Director.

Failing to identify all staff who were present or responded to an incident of resident to resident abuse resulted in an incomplete investigation into the incident.

Sources: CI, health record of two residents, home investigation notes, staffing schedules and interview with the Administrator.
[111]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)

1.The licensee failed to ensure that a final report was provided to the Director for an alleged resident to resident abuse incident.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident. The CI indicated under outcome of individuals and under the analysis and follow-up-section, they were to be completed and updated upon further investigation. A final report was never provided to the Director. The DOC indicated the allegation was determined to be founded and the final report to the Director was not provided.

Failing to provide a final report to the Director within the specified time of 21 days, for the alleged resident to resident abuse involving two residents resulted in no investigation being documented.

Sources: CI, health record of two residents and interview of the DOC.
[111]

2.The licensee failed to ensure the Director was provided a final report regarding the alleged resident to resident abuse involving two residents.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident. There was no final report with the outcome of the investigation provided to the Director. The DOC confirmed they did not provide a final report to the Director, but the outcome was determined to be founded as abuse.

Failing to provide a final report to the Director for alleged resident to resident abuse involving two residents results in a delay in the results of the investigation.

Sources: CI, health record of two residents and the DOC.
[111]

COMPLIANCE ORDER CO #001 Responsive Behaviours

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with O.Reg. 246/22, s. 58(4)(b).

Specifically, the licensee shall:

1.Review and revise the zero tolerance of abuse and neglect policy, to ensure it contains procedures on how to respond when abuse of a resident is by another resident.
2.Review and revise the plan of care for resident #002 to ensure all their responsive behaviours, triggers and effective strategies are clearly identified to respond to those behaviours, especially the frequency of monitoring.
3.Ensure there are appropriate devices readily available and accessible in the home (i.e., motion sensors/wander guards) for residents #002, who require additional monitoring.
4.Retrain RN #111 to ensure they are aware of their roles and responsibilities related to the home's revised zero tolerance of abuse and neglect policy and their responsive behaviour policy, specifically when there has been an altercation between two residents and the resident is injured or has pain, documentation, and notification requirements.
5. Education records should be kept onsite and made available to Inspectors upon request.

Grounds
1) The licensee failed to ensure that for a resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Rationale and Summary

A CI was submitted to the Director for an alleged resident to resident abuse incident. One of the residents sustained an injury, was transferred to hospital, and died a number of days later.

One of the residents involved in the incident had a history of specified responsive behaviours and had a number of previous incidents prior to the CI. The resident was identified by the Behavioural Support Ontario (BSO) with specified responsive behaviours and the strategy to prevent a recurrence included monitoring the resident during a specified time, but no indication how this was to occur. There were no strategies identified in their plan of care to manage the resident's other responsive behaviours and that occurred at other times of the day. At the time of the inspection, the resident was observed at different dates and times demonstrating those responsive behaviours and was occasional monitored by staff. The resident was also with the Inspector for a period of time before staff came to monitor the resident that was greater than the frequency of monitoring that was to be in place. An RN indicated the resident was to be on a specified monitoring frequency. They also indicated another strategy had been implemented to manage one of the responsive behaviours but was discontinued as it was disrupting them. The DOC indicated they were going to order a specified monitoring device as they had none in the home.

Failing to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours, specifically during specified times, resulted in another resident sustaining a serious injury and subsequent death.

Sources: CI, health records of two residents, BSO whiteboard, observations of a resident and interviews of registered staff and the DOC.
[111]

2) The licensee failed to ensure that for a resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Rationale and Summary

There were a number of separate CIs submitted to the Director for witnessed, alleged or suspected resident to resident abuse incidents involving a resident towards a number of other residents. Some of

the incident resulted in other residents sustaining injuries and other incidents resulted in the resident themselves, sustaining injuries. During each of the incidents, there was no one to one (1:1) monitoring in place.

The resident had a history of specified responsive behaviours that occurred at different times of the day. The residents plan of care indicated they were on 1:1 monitoring, but no indication when it started, when it was to be in place or for how long. The resident was observed on different dates and times with 1:1 monitoring in place. An RN indicated the resident had previously been on 1:1 monitoring during a specified shift, for a number of months and was increased to two specified shifts after a number of incidents had occurred. The RN indicated the resident's 1:1 monitoring had not increased to 24 hours per day until after the last incident that occurred, during the time of the inspection. The RN confirmed there was no 1:1 monitoring in place when each altercation occurred. The RN indicated the resident was trialed with a sensor device after the first incident but was discontinued as it was disrupting the resident's sleep. A PSW and another RN also confirmed there was no 1:1 present during the incident that occurred during the specified shift that the resident was supposed to be on 1:1 monitoring. The DOC confirmed awareness of ongoing incidents of resident-to-resident abuse by a resident. The DOC indicated they had ordered a different alarming device after the last incident.

Failing to ensure that strategies were developed and implemented to respond to a resident's specified responsive behaviours resulted in multiple residents being fearful of the resident, sustaining injuries or pain and the resident sustaining injuries.

Sources: Multiple CIs, observations and review of health records for a number of residents, BSO whiteboard, and interview of PSW, registered staff and DOC.
[111]

This order must be complied with by May 25, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.