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

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Original Public Report

Report Issue Date: July 13, 2023

Inspection Number: 2023-1069-0002

Inspection Type:
Follow up
Critical Incident System

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

Long Term Care Home and City: Springdale Country Manor, Peterborough

Lead Inspector	**Inspector Digital Signature**
Nicole Jarvis (741831)	Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2023.07.19 10:12:47 -04'00'

Additional Inspector(s)
Amy Bushey (000746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5-9, 12-15, 2023

The following intake(s) were inspected:

- Intake: #00084126 - related to staff to resident verbal abuse.
- Intake: #00085310 - Intake: #00086412 - related to resident-to-resident responsive behaviours/ altercations.
- Intake: #00086549 - related to fall of resident.
- Intake: #00086809 - CO #001 from inspection 2023_1069_0001, O. Reg. 246/22 - s. 58 (4) (b), CDD May 25, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1069-0001 related to O. Reg. 246/22, s. 58 (4) (b) inspected by Nicole Jarvis (741831)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Quality Improvement
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 356 (3) 1.

The licensee has failed to request approval of the Director for the altercations to resident space.

Rationale and Summary

The IPAC Lead indicated that Personal Protective Equipment was being stored in the McKenize Room. Inspector observed boxes of supplies. This room was equipped with a locked door handle.

When asked, the Director of Care confirmed this room was a resident's space being used as a storage room for their pandemic supplies. The alterations to the resident space were not approved by the Director.

The licensee acted by removing the supply boxes and restored the McKenize room to a resident space.

The failure to receive approval of the Director to alter resident space could negatively impact the quality of life of the residents.

Sources: Observations in all home areas, interviews with IPAC Lead, Director of Care. [741831]

Date Remedy Implemented: June 8, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 115 (5) 4.

The licensee failed to inform the Director of an incident within 10 days of becoming aware of the incident. Specifically, the analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

Rationale and Summary

A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care indicated a resident was discovered on the floor. The resident was sent to the hospital for further assessment.

During a record review, the Physiotherapist completed an assessment and completed a fall review with the nursing team to implement strategies to prevent immediate and future reoccurrence.

The Director of Care did not complete the report in entirety to the Director. Specifically, the immediate actions, and the long term planned to prevent recurrence. The report in entirety was submitted to the Director 44 days after the significate incident had occurred.

Source: Critical incident report, Resident record review, Interview with Director of Care. [741831]

Date Remedy Implemented: June 5, 2023

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure resident #006 and all other residents were protected from abuse by staff.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident verbal abuse.

The CIR indicated allegations that PSW #112 yelled at a resident.

During a record review of the home investigation package, the witness completed a written statement indicating an ongoing concern with PSW #112. The concern expressed that the resident was crying because they were left in the wheelchair, not assisted to bed as normal routine, and not assisted to the toilet. The account explained the witnessed alleged abuse in detail as noted in the CIR and stated that PSW #112 did not provided proper care or assistance to the toilet for any of their assigned. The witness explained it was their duty to report abuse / neglect without any repercussions and they hope that this account would not be taken lightly.

In an interview with PSW #114, they indicated the resident started crying after PSW #112 yelled in their face. They said the resident was scared. PSW #114 explained they just recently completed their annual Zero Tolerance of Abuse training and felt obligated to report what they witnessed. PSW #114 did not see the resident later that shift and unable to confirm the effects on the resident after the witnessed event.

The PSW submitted the alleged abuse in an email to the Administrator.

PSW #112, the alleged abuser was noted to be off the schedule due to illness, and vacation. They returned to work and continued to work additional three shifts before an investigation interview were completed by the licensee. PSW #112 continued to work in the home and cared for residents for six shifts after the witness abuse incident.

The Administrator and Director of Care confirmed PSW #112 continued to care for residents within the home while attempting to arrange an investigative interview with PSW #112.

The licensee failed to protect resident #006 and any other resident from abuse by allowing PSW #112 to continue to work in the home following an allegation of abuse. The licensee did not have interventions put in place to safeguard the residents, after an alleged abuse was reported.

Sources: Critical incident Report, licensee investigation notes, Interviews with PSW #114, Administrator and Director of Care. [741831]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident verbal abuse.

The CIR indicated allegations that PSW #112 yelled at a resident.

Through record reviews and an interview with the Director of Care there was no evidence that the resident was provided support or assessed for any additional treatment including psychosocial after the witnessed allegation of abuse. The homes policy for Zero Tolerance of Abuse and Neglect of residents was not followed.

The Administrator and Director of Care indicated the resident was cognitively impaired and most likely did not remember the incident. PSW#114 expressed the resident was scared after the witnessed allegation of verbal abuse.

The licensee failed to comply with the Zero Tolerance of Abuse and Neglect of Residents policy, procedure, and interventions after an alleged or witness incidents. This put residents at undue risk of physical and emotional harm.

Sources: Critical Incident Report (CIR) , Zero Tolerance of Abuse and Neglect of Residents Policy, Interview with PSW#114, Administrator and Director of Care. [741831]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident verbal abuse.

Review of the licensee's internal investigation revealed that the homes investigation of the allegation towards PSW #112 did not occur until 26 days after the incident. The accused continued to work within the home and with the residents for six shifts before the licensee arranged an investigation meeting with accused staff.

The Administrator and Director of Care confirmed PSW #112 continued to care for residents within the home while attempting to arrange an investigative interview. The Director of Care recognized the investigation was not completed timely. They indicated that the delay in the investigation was due to the in availability of the PSW and Management.

The licensee failed to ensure every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, specifically abuse of a resident by anyone which put the residents at risk.

Sources: Critical incident Report, licensee investigation, Interviews with PSW #114 Administrator and Director of Care. [741831]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure a person who has reasonable ground to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care regarding alleged staff to resident verbal abuse.

The allegations of verbal abuse was reported to the Director two days after the incident took place.

The Administrator confirmed all staff members were trained on the reporting requirement annually.

The licensee failed to ensure a person immediately reports any suspicion of abuse of a resident which potentially put residents at risk of harm.

Source: Critical Incident Report, Record review of licensee's investigation package, Interview with Administrator and PSW #114. [741831]

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary

It was observed a linen room door unlocked by a magnetic blocking the locking mechanism on the handle to function. During the observation, a resident stated to the inspector that the room is always unlocked.

Observation of the linen room revealed it did not have access to a resident communication and response system.

The Inspector spoke with Director of Care regarding the non-residential access. When asked, the Director of Care indicated these rooms were required to be locked.

After the concern of unlocked doors leading to non-residential areas was brought forward to the Director of Care and the Administrator in the home; the Inspector observed the Boardroom door left open on several occasions. There was a sign on the door that stated the door must remain closed. During observation there was no communication and response system available in the Boardroom and the room was left unsupervised.

Failure to ensure non-residential areas doors are kept locked and closed when no supervision by staff put residents in potential risk of harm without the access to the communication call and response system.

Sources: Observations throughout the inspections, Interviews with Director of Care and Administrator. [741831]

WRITTEN NOTIFICATION: Communication and response system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)

The licensee has failed to ensure that their home is equipped with a resident-staff communication and response system that is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary

The intention of the communication system is to clearly indicate when activated, where the signal is coming from. The system observed in the Long -Term Care Home was designed to use pagers to alert the direct care staff wherever they are in the home, when activated. Observations were made of the communication and response system throughout the Long-Term Care Home. There were two audio/visual panels located at the north and south nursing station. The communication system also consisted of a light outside of the resident's room which lit when activated but was not audible. When the call-bell was activated, Inspector was able to hear an audible sound from the audio/visual panel at the nursing station when present within the proximity. It was observed that when you travel down the corridors or further away from the audio/visual panel, the Inspector was unable to hear the audible sound.

During observations, Inspector asked PSW#108 and PSW#109 if they had a pager for the communication and response system. The staff explained that they did not have pagers available to them. The staff indicated they were required to observe the activation lights outside of the resident's room when walking in the hallways. PSW#108 confirmed that the visual panel at the nursing station did have an audible sound but the staff were not able to hear the audible sound when they are down the hallway or in a resident's room. PSW #108 indicated that when the home is working with less team members than assigned, and a team member requires assistance, they are often having to leave the resident and physically find someone for secondary support. The PSW indicated that the home had been without pagers for a while.

The Director of Care confirmed the direct care staff had been without pagers for a few months. They stated that the pagers often go missing and they have not been replaced. The Director of Care confirmed the team members were not able to hear the audible sound of the audio/visual communication panel in all locations of the home without the pagers. There was no immediate plan in place to replace the missing pagers.

When the licensee failed to ensure the resident's home was equipped with a resident-staff communication and response system that was properly calibrated so that the level of sound was audible to staff, created a risk to the resident's safety and well-being.

Sources: Observations through the home, interviews with PSW#108, PSW #109 and Director of Care. [741831]

WRITTEN NOTIFICATION: Hazardous substances

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee has failed to ensure that all hazardous substances are keep inaccessible to residents at all times.

Rationale and Summary

During the inspection observations we made of the whirlpool door unlocked and one occasion the whirlpool door was left open with no staff present. When the Inspector completed observations of the whirlpool room, hazardous substances were present. Specifically, a cleaning product (peroxide) was

accessible.

During separate interviews RN #103 and PSW#104 confirmed the whirlpool doors should remain closed and locked. The team members previously had individual keys to access these rooms when required. At the time of the observations the staff were required to ask a Registered Nurse or management to open the door because they did not have access to a key. RN #104 explained that team members had access to a key attached to a communication and response system pager. The team members no longer had pagers available.

Director of Care confirmed that the door must remain closed and locked.

RPN #113 indicated the home had created a new process for staff to sign in and out keys during their shift to have access to the whirlpool and linen rooms without having to ask the nurses.

Following the homes implementation of the new process for signing out keys, the Inspector completed another observation of the whirlpool rooms. It was observed a whirlpool door was propped open and hazardous substances were accessible.

The licensee failed to ensure that all hazardous substances were kept inaccessible to residents at all times, there was a potential risk of harm to residents.

Sources: Observations, interview with RN #103, PSW #104, Director of Care, RPN #113. [741831]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

1. Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of-care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary

During the inspection, it was observed several automatic Alcohol-Based Hand Rub (ABHR) dispensers in the hallways were not functioning on four dates during the inspection. On June 9, 2023, Inspector #000746 completed observations of ABHR in some resident's room at the point-of-care. There were 29 resident rooms observed. It was identified that 12 of out the 29 ABHR in resident's rooms were not functioning, and 3 out of the 29 resident room dispensers were empty. During the Inspector's information gathering, the IPAC Lead stated that there were 400 batteries on order that day. When asked what the home's plan was while waiting for the batteries, the IPAC Lead indicated they were not sure what the contingency plan was until then. The same day, the IPAC Lead later confirmed that there were ABHR hand pumps available in all the resident's rooms that did not have a functioning automatic ABHR dispenser.

The Long-Term Care home was declared in outbreak on June 13, 2023 as indicated in the Critical Incident Report. During the inspection the identified rooms on isolation precautions on were resident rooms that did not have immediate access to ABHR at point-of-care.

The licensee failed to ensure immediate access to 70-90% Alcohol Based Hand Rub (ABHR) at point-of-care; there was a risk of ineffective hand hygiene and risk for transmission of infectious agents to the residents.

Source: Observations throughout the home, interview with the IPAC Lead, Critical Incident Report. [741831] [000746]

2. Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s.10.4 The Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary

During the inspection it was observed that residents were not being offered or supported with hand hygiene prior to the morning and afternoon snack.

During the morning nourishment the Inspector did not observe Alcohol - Based Hand Rub (ABHR) available to support residents with hand hygiene. PSW #100 indicated that the home did not have a procedure in place for hand hygiene prior to snacks, only prior to meal service. During the afternoon nourishment Inspector observed ABHR on the nourishment cart. The residents were not being

supported with hand hygiene prior to receiving their snack. PSW#105 indicated the ABHR pump was for the staff to complete hand hygiene in between resident. PSW#105 confirmed that residents did not use the ABHR during nourishment.

The IPAC Lead indicated that residents were supported with hand hygiene at mealtimes and activities. When Inspector asked specifically if residents should be supported with hand hygiene during nourishment, they indicated that they should support residents with hand hygiene at nourishment as well.

The DOC indicated the expectation of hand washing for residents prior to nourishment; was required but indicated it was not a practice within the home.

The licensee failed to ensure the residents were supported with hand hygiene prior to nourishments, there was a risk for transmission of infectious agents.

Sources: Observations of residents being provided a snack, interviews with PSW #100, PSW #105, IPAC Lead and Director of Care. [741831]

WRITTEN NOTIFICATION: Police notification

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary

A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care, indicated that resident #001 applied physical force to resident #002. This incident resulted with resident #002 sustaining an injury.

The incident was reported to the Director through the afterhours reporting system. In the after hour report it stated that police may be called by on-call manager/Director of Care if they felt it was necessary.

The local Police were notified three days after the incident through a "Long Term Care Homes Elder Abuse Reportable Incident Form" that was emailed to the Peterborough Police Service.

During an interview, the Director of Care confirmed the emailed report was not immediately sent at the time of the incident.

When the licensee failed to contact the police service immediately of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, they put residents at further risk of physical and emotional harm.

Source: Interview with Director of Care, the Long-Term Care Home investigation package. [741831]