Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
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Original Public Report

Report Issue Date: February 15, 2023	
Inspection Number: 2022-1241-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Osgoode Care Centre	
Long Term Care Home and City: Osgoode Care Centre, Metcalfe	
Lead Inspector Gurpreet Gill (705004)	**Inspector Digital Signature**
Additional Inspector(s) Michelle Edwards (655)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 19-21, 25-28, 31, November 1-4, and 7-10, 2022.

The following intake(s) were inspected:

- Intake: #00004055-[CI: 2747-000011-22] related to a fall incident that caused injury to a resident
- Intake: #00004903-[CI: 2747-000007-22] related to a fall incident that caused injury to a resident
- Intake: #00006571-[IL: IL-99233-OT] Complaint related to care and services to residents, documentation, and insufficient staffing
- Intake: #00006984-[AH: IL-01307-AH/CI: 2747-000008-22] related to alleged resident to resident physical abuse
- Intake: #00007279-[IL: IL-04992-OT] Complaint related to maintenance issues and fall of a resident

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- The following intakes were completed in the critical Incident System Inspection: Intake: #00002074, CI: 2747-000010-22 and Intake: #00006828, CI: 2747-000006-22 were related to a fall incident that caused injury to a resident

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

Housekeeping, Laundry and Maintenance Services
Falls Prevention and Management
Reporting and Complaints
Responsive Behaviours
Prevention of Abuse and Neglect
Infection Prevention and Control
Resident Care and Support Services
Staffing, Training and Care Standards

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 (1) (c)

The licensee failed to ensure that there was a written plan of care for the resident that set out clear directions to staff and others who provide direct care to the resident, related to the resident's toileting plan.

Rationale and Summary

In a critical incident report (CIR), it was indicated that the resident had fallen on a day in April 2022, when they attempted to self-transfer from their wheelchair to the toilet. In the same CIR it was indicated that the resident had a history of falls, including a fall that occurred on a prior date in April 2022, at which time the resident had also been transferring to the toilet.

In the resident's current Kardex, it was indicated that the resident was to be assisted to the bathroom by two staff members, within one half hour of the scheduled toileting times. There were no identified scheduled toileting times on the Kardex reviewed, or in the resident's current care plan.

A PSW indicated that the resident was on a toileting plan and demonstrated that there was one scheduled toileting time in the point of care (POC) records used to document care provided by staff to the resident. At the same time, however, the PSW indicated that they would otherwise toilet the resident as needed and that, depending on what other staff member was assisting, they would sometimes change the resident in bed instead of toileting them.

In the resident's written plan of care, only one toileting time was specified. As such, the licensee failed to ensure that the resident's written plan of care included clear directions to staff. For this reason, the resident was at risk for falls related to the potential for self-transfer attempts.

Sources: The resident's health care record and Interview with an identified staff member. [655]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the resident's chair (tab) alarm was not applied on a day in April 2022, as required.

Rationale and Summary

On a day in April 2022, the resident sustained an injury as a result of a fall.

Over the course of the inspection, it was determined that the resident was required to have a chair (tab) alarm in place when they were in their wheelchair, for the purpose of falls prevention, at the time of the fall in April 2022.

According to a related critical incident report (CIR), the resident had attempted to self-transfer from their wheelchair to the toilet at the time of the incident. In the same CIR, it was indicated that a tab alarm was available at the time of the fall but had not been applied.

A PSW recalled the above-noted incident. According to the PSW, they had been alerted to the fall of the resident on a day in April 2022, by a co-resident who reported hearing a loud noise. The PSW indicated that there was no alarm sounding at the time. At the same time, the PSW indicated that the resident did

use a tab alarm for the purpose of falls prevention, but the tab alarm is not always applied as required, explaining that it does get forgotten.

As such, the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. As a result, the resident was at risk for a recurrent fall.

Sources: The resident's health care record and Interview with an identified staff member. [655]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for two residents.

Rationale and Summary

The point of care (POC) documentation for a resident showed that for the month of March 2022, there were three days where the resident's bath was not documented.

The point of care (POC) documentation for another resident showed that for the month of March 2022, there was one day where the resident's bath was not documented.

The Director of Care (DOC) indicated that residents received their scheduled biweekly bath but the staff did not complete their documentation in the POC. Therefore, the provision of care set out in both residents' plan of care regarding the bath was not documented.

Sources: Residents' health care records and interview with the DOC. [705004]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 76 (7) 6.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the area of falls prevention and management at times or at intervals provided for in the regulations.

In accordance with Ontario Regulation (O. Reg) 79/10, s. 221 (1) and (2), the licensee was required to ensure that annual training was provided in the area of falls prevention and management to all staff who provide direct care to residents.

Rationale and Summary

During an interview, a PSW indicated that they could not recall whether they had received training in the area of falls prevention and management.

The Director of Care (DOC) was unable to locate any record that was indicative that falls prevention and management training had been provided to identified staff members in 2021.

During an interview, President and Chief Executive Officer (CEO) indicated that not all direct care staff had received training in the area of falls prevention and management in 2021.

The licensee failed to ensure that all staff who provide direct care to residents received training in the area of falls prevention and management in 2021. A lack of staff training in the area of falls prevention and management potentially increases the likelihood of falls among residents.

Sources: Interview with identified staff members. [655]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead designated under this section works regularly in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary

Interviews with the President & Chief Executive Officer and IPAC lead indicated that the designated IPAC lead worked 15 hours per week.

As such not having a designated IPAC lead regularly on-site may affect the home’s IPAC program. As the

designated IPAC leads primary responsibility is to oversee the infection, prevention and control program and work with the interdisciplinary team to implement, manage and oversee the infection prevention and control program.

Sources: Interviews with the President & Chief Executive Officer and IPAC lead. [705004]

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee failed to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented when a resident was not assessed quarterly for risk for falls.

As a required program, the falls prevention and management program must provide for screening protocols, and assessment and reassessment instruments (O. Reg. 246/22, s. 53 (2) (a) and (b)); and must include written policies and strategies to reduce or mitigate falls, including the monitoring of residents. (O. Reg. 246/22 s. 34 (1) (1)).

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, the licensee failed to ensure that the policy titled Falls Prevention and Management (Policy #VI-G-10.58) (current revision: March 2022) was complied with.

Rationale and Summary

According to the above-noted policy, registered staff were required to conduct a Falls Risk Assessment on a quarterly basis.

The Falls Risk Assessment, when completed, generates a resident-specific score that corresponds with a fall risk level, which informs the development of a resident's plan of care for the purpose of reducing or mitigating risk for a fall.

A review of the resident’s health care records revealed that the resident fell ten times between January 2022, and November 2022. However, there was no indication that the resident had been assessed using the Falls Risk Assessment on a quarterly basis, as required by the licensee's policy.

During an interview, the Director of Care (DOC) indicated that the fall risk assessments had not been completed for the resident on a quarterly basis.

Sources: The resident's health care record, the licensee's policy titled Falls Prevention and Management (Policy #VI-G-10.58) (current revision: March 2022) and an interview with the Director of Care. [655]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

A) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to the point-of-care signage indicating that enhanced IPAC control measures are in place as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

On November 4, 2022, the inspector observed that three residents has a red dot on the nameplates on their doors. But there was no signage posted at the entrance to residents' rooms or bed spaces indicating that enhanced IPAC measures were in place for residents on additional precautions.

A PSW indicated that residents on additional precautions have a red dot on their nameplates and the contact precaution signages supposed to be posted in residents' bed spaces.

As such, not having signage for additional precautions, posing infection control risks among residents and staff.

Sources: Interview with the identified staff member and observations made by the inspector.[705004]

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

B) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to personal protective equipment (PPE) availability and accessibility to staff, appropriate to their role and level of risk as is required by Additional Requirement 6.1 under the IPAC Standard.

Rationale and Summary

On November 9, 2022, the inspector observed that five residents in the south unit and four residents in the west unit were identified to be on additional precautions. All nine residents were on contact precautions as per the sign on their bed space. But did not have PPE supplies outside of residents' rooms or in the south and west unit hallways. The Infection Prevention and Control (IPAC) lead indicated that each unit has a PPE cart in the hallway.

Interviews with three staff members indicated that they wear only gloves when they were providing direct care to residents who required contact precautions. Two of the staff members indicated they wear gowns when residents are on COVID precautions. Of the two one of the staff members indicated that they believed that PPE supplies (gowns) are in the supply room.

The "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), specifies that the licensee must ensure that the PPE available and accessible to staff, and having PPE supply in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

Failing to participate in the implementation of the IPAC standard increases the risk of disease transmission among residents and staff when the resident is required to be in additional precautions.

Sources: Interviews with the identified staff members and observations made by the inspector. [705004]