



**Ministry of Health and  
Long-Term Care**

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

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 6, 2016	2016_330573_0018	013547-16	Resident Quality Inspection

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### **Licensee/Titulaire de permis**

TOWNSHIP OF OSGOODE CARE CENTRE  
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE  
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

ANANDRAJ NATARAJAN (573), RENA BOWEN (549)

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## **Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): August 29, 30, 31, September 01, and 02, 2016.**

**Concurrent Critical Incident Inspection Log #:027050-16, related to a resident fall which resulted in significant change in health condition was inspected.**

**During the course of the inspection, the inspector(s) spoke with Residents, Family members, Residents' Council Leadership team member, Personal Support Workers (PSW), Housekeeping Staff, a Physiotherapy Assistant, Registered Practical Nurses (RPN), Registered Nurses (RN), the Physiotherapist, the RAI Coordinator, Food Service Manager, Director of Life Enrichment, the Facility Manager, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Executive Director.**

**During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed a medication pass including medication room, observed recreation activities, observed exercise therapy classes, reviewed minutes for Residents' Council and reviewed Resident Health Care records.**

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

**Continance Care and Bowel Management**

**Falls Prevention**

**Family Council**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Residents' Council**

**Skin and Wound Care**



**During the course of this inspection, Non-Compliances were issued.**

- 4 WN(s)**
- 0 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

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

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**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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**

**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**

**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**

**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the care set out in the plan of care was provided to resident #006, as specified in the plan.

The current plan of care and the most recent assessment completed by the Physiotherapist, for resident #006 indicates the provision of the multiple physiotherapy interventions for resident #006 due to increased risk for falls.

- 1- Range of motion exercises upper and lower limbs 5- 10 reps
- 2- Strengthening exercises, standing balance exercises at wall bar
- 3- Transfer practice at transfer pole with one assist
- 4- Ambulation with walker support one assist

The frequency of the physiotherapy interventions indicated three times a week by the physiotherapist assistant (PTA) under the direction of physiotherapist.

On August 31, 2016, PTA #115 indicated to Inspector #573 that resident #006's physiotherapy interventions include range of motion exercises/ strengthening exercises/ standing balance exercises/ transfer practice at transfer pole and ambulation with walker support. Further she indicated that resident was seen three times a week for the physiotherapy interventions as specified in the plan of care.

The physiotherapy daily attendance sheets, used by the home to record the provision of

physiotherapy services, for the month July and August 2016, indicates:

- for the week of July 04-08, 2016: Ambulation on two specific days.
- for the week of July 11-15, 2016: Ambulation provided on one specific day.
- for the week of July 18-22, 2016: Ambulation provided on one specific day.
- for the week of July 25-29, 2016: Ambulation on two specific days.
- for the week of August 01-05, 2016: Ambulation provided on one specific day.
- for the week of August 08-12, 2016: Ambulation on two specific days.
- for the week of August 15-19, 2016: Balance and Range of motions exercises on two specific days.

On August 31, 2016, the home's Physiotherapist indicated to Inspector #573 that for resident #006, the ambulation was the priority and PTA should provide physiotherapy interventions as specified in the plan. Further she indicated that resident should be seen three times per week for physiotherapy treatment by the PTA unless otherwise resident refuses for treatment or resident is absent, and that should be documented in the physiotherapy notes. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #013's Minimum Data Set (MDS) assessment on a specified date indicated that the resident has a Cognitive Performance Scale (CPS) of five and cognitive skills for daily decision-making is severely impaired- never/rarely made decisions. The MDS assessment also indicated that the resident requires a mechanical lift for all transfers and is totally dependent for care.

On August 29, 2016, resident #013 was observed by Inspector #549 to have red/purple discolouration on specific parts of the resident's extremity.

During an interview on August 31, 2016, PSW #104 indicated that resident #013 can be resistive to care and will hit her/his extremity on the mechanical lift when in use leaving bruising at times. PSW #104 indicated that staff will attempt to hold the resident's hands to prevent the resident from hitting them on the metal part of the mechanical lift.

Inspector #549 reviewed the resident's flow sheet which indicated that the resident was resistive to care 13 of the 31 days on a specific month in 2016.



The interdisciplinary care conference notes for resident #013 dated on a specified month in 2016, indicated under the section titled Mood/Behaviours: can be resistive to care at times. Under the section titled Cognition/Communication: is quiet but usually pleasant and can be resistive by times.

The head to toe skin assessments on a specified day, indicated that the resident had bruising on specific body parts.

Inspector #549 reviewed resident #013's progress notes on a specified month in 2015, which indicated that the resident's family member had requested that the resident's bed rails to be padded as the resident was banging her/his extremity on them.

The current written plan of care dated on a specified date, provided by the Director of Care was reviewed by Inspector #549. The written plan of care does not indicate that the resident's bed rails are to be padded to prevent any injury, or that the resident is resistive to care at times and will hit her/his extremity on the mechanical lift leaving bruising at times.

The current written plan of care also indicated that resident #013 is currently on anticoagulant therapy. Inspector #549 reviewed resident #013's current medication administration records (MARS), which did not indicate that the resident was on anticoagulant therapy. On a specified date in 2016 Inspector #549 reviewed resident #013's physician's orders and observed that five months before the anticoagulant therapy was discontinued.

In summary the licensee has failed to ensure that the plan of care for resident #013 was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary related to anticoagulant therapy, being resistive to care at times, the interventions to prevent bruising when the mechanical lift is used and the bed rails requiring padding to prevent injury to the resident. [s. 6. (10) (b)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**



**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**

**15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #014's plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Resident #014 was admitted to the home on a specified date with multiple diagnosis. The resident receives non-steroidal anti-inflammatory drug and wears stocking.

On August 29, 2016, Inspector #549 observed that the resident had dark red/purple marks on her/his extremity with a small dressing . The resident was also observed to have edema in face, both upper, lower extremity and a significant amount of edema in a specific extremity.

Review of the residents Head to Toe Assessments completed by the registered staff for three specified months in 2016 indicated that the resident had multiple skin integrity issues including bruising, skin tear, pressure sore and edema.

Resident #014 was assessed by the Skin Care Coordinator twice in 2016 related to a skin abrasion. The resident's extremity was edematous and shiny at the time of the assessment.

During an interview on August 31, 2016, PSW #107 and PSW #106 indicated that they are not aware of any skin condition, including altered skin integrity and foot condition in providing care for resident #014.

During an interview RPN #101 indicated to Inspector #549 that the resident's lower extremity were edematous. RPN #101 also indicated that resident #014's specific body area had been weeping due to edema but does not recall the date.

The Director of Care provided the current plan of care on a specified date, to Inspector



#549. RPN#101 and Inspector #549 were unable to locate any documentation indicating resident #014's skin condition, including skin integrity and foot conditions.

On September 01, 2016, during an interview the Assistant Director of Care indicated that the home's expectation is that all resident's will have their skin condition, including altered skin integrity and foot condition documented in the resident's plan of care.

In summary the plan of care is not based on at a minimum an, interdisciplinary assessment of resident #014's skin condition, including altered skin integrity and foot conditions. [s. 26. (3) 15.]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57.  
Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**





1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Resident #024, a member of the Residents' Council Leadership team, indicated to Inspector #573 that the Council did not receive written response within 10 days from the Licensee regarding any concern or recommendation made by the Council.

Inspector #573 reviewed the latest Resident's Council meeting minute's binder for the month of June 29, 2016. The meeting minutes identified resident's concerns regarding nursing and personal care.

- Recommendations /Concerns regarding the bins (on south unit), where staff put garbage/ soiled continence products, gets very smelly throughout the day.
- Recommendations /Concerns regarding part - time PSW staff are not familiar with the care needs of the residents.
- Recommendations /Concerns regarding residents should be helped to wash first in the morning and then put their clean clothes on for the day.
- Recommendations /Concerns regarding residents would like to know when the next eye clinic is being held in the home.

On September 01, 2016 during an interview with the home's Director of Life Enrichment, who does the assistant duties for the Residents' Council indicated that any concerns or recommendations from the Resident's Council is documented and sent to the appropriate department. The Director of Life Enrichment indicated that she will receive the written response from the specific department within 10 days and the written response is communicated to the Resident's Council in the subsequent meeting. Further she stated to inspector that a written response to the Resident's Council meeting concerns for the month of June 29, 2016, was not provided to the Resident's Council as of September 01, 2016. [s. 57. (2)]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**



**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee consult regularly with the Residents' Council, and in any case, at least every three months.

Resident #024, a member of the Residents' Council Leadership team, indicated to the Inspector #573 that the licensee does not consult regularly with the Residents' Council.

During an interview with the Director of Life Enrichment, who indicated to Inspector that she was assigned to assist the Residents' Council, and she does not represent the licensee. Further she indicated that the home's Executive Director who represents the licensee will consult with the Residents' Council once every year.

The Home's Executive Director indicated to Inspector #573 that she was designated to represent the licensee. Further she indicated that she had not consulted with the Residents' Council since September 2015. [s. 67.]

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**Issued on this 6th day of September, 2016**

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

**Original report signed by the inspector.**