Ontario

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2018_658178_0001	024650-17	Resident Quality Inspection

Licensee/Titulaire de permis

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

SUSAN LUI (178), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 2, 3, 4, 5, 8, 9, 10, 11, February 7, 2018.

The following Critical Incident Logs were inspected as part of this Resident Quality Inspection (RQI):
005628-17, related to an alleged incident of resident to resident sexual abuse
020576-17, related to an allegation of staff neglect of a resident
008762-17, related to an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with: residents, family members, a member of the Residents' Council Leadership Team, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Human Resources Generalist, Environmental Manager, Director of Life Enrichment, Director of Care (DOC), Executive Director.

During the course of the inspection, the inspectors toured the home, observed resident care being provided, medication administration passes, and infection prevention and control practices. The inspectors reviewed resident health care records, employee training documents, and the Residents' Council general meeting minutes. The inspectors reviewed documentation related to the home's investigations into the above critical incidents, and home policies related to the prevention of abuse and neglect, and the use of Personal Assistance Service Devices (PASDs).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **5 WN(s)**
- **1 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	Legendé 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #024, who was unable to toilet independently some or all of the time, received assistance from staff to manage and maintain continence.

An identified Critical Incident Report (CIR), submitted by the licensee, indicated that on an identified date, resident #024 reported that on the previous evening no one responded to the call bell when the resident rang for assistance to get off of the commode, and as a result the resident remained on the commode for a period of time until receiving assistance.

Review of resident #024's plan of care in place at the time of the incident, indicated that the resident suffered from impaired mobility, and was to be provided with weight bearing support when asked, to assist with transfer on/off the toilet and extensive assistance with adjusting clothing.

During an interview between Inspector #178 and the home's DOC on January 10, 2018, the DOC indicated that on an identified date, resident #024 reported to day staff that on the previous evening the resident rang for assistance to get off the commode, but no one answered the bell for a period of time. The DOC indicated that the plan of care for resident #024 called for one person to assist with transferring. An investigation was conducted by management staff, and it was determined that PSW #117 had failed to assist the resident off the commode after the resident rang the bell and asked the PSW for assistance verbally when PSW #117 entered the resident's room. Further, PSW #117 left the home at the end of the shift, with resident #024's bell ringing, and the resident still on the commode. The resident was not harmed as a result of the incident, and was assisted to bed by a PSW from the subsequent shift. PSW #117's employment was terminated after the investigation was concluded.

During an interview with Inspector #178 on January 11, 2018, PSW #118 indicated that on an identified date, resident #024 was left on the commode for a period of time after being placed on the commode by PSW #117. PSW #117 then left at the end of the shift without reporting to other staff that the resident remained on the commode.

In conclusion, the licensee failed to ensure that resident #024, who was unable to toilet independently some or all of the time, received the required assistance from staff to manage continence.
(020576-17) [s. 51. (2) (c)]

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 residents who are unable to toilet independently some or all of the time, receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reported the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act (LTCHA).

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During a review of resident #005's health care record the Inspector discovered a progress note from an identified date, written by RN #116 describing an incident whereby resident #005 was observed rubbing resident #025's limb over the clothing, while resident #025 was asleep. Resident #005's plan of care identified that resident #005 exhibits identified inappropriate behaviour of this type. The RN spoke with resident #005 to stop the behaviour, and informed the resident that the behaviour was not acceptable. The RN removed resident #005 away from the sleeping resident #025.

During an interview with Inspector #573 on January 10, 2018, RN #116 indicated that on an identified date, the RN observed resident #005 rubbing resident #025's limb over the clothing. The RN indicated to the inspector that resident #005's behaviour towards resident #025 was inappropriate and sexual in nature. Further, the RN indicated that the act was non-consensual since resident #025 was sleeping. RN #116 indicated that he/she was the in-charge RN on the shift when the incident occurred. RN #116 indicated that he/she did not report the incident to the Director under the LTCHA, the home's DOC, or the Administrator.

During an interview with Inspector #573 on January 10, 2018, the DOC indicated to the Inspector that she was not aware of the incident on the above identified date. The DOC indicated that the incident should have been immediately reported to the MOHLTC and to the manager on call by the RN #116 in charge.
(005628-17) [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/inhibits freedom of movement and which the resident is physically or cognitively unable to remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent from the resident or the resident's substitute decision maker, has been obtained and documented.

On two identified dates, Inspector #573 observed resident #002 sitting in a wheel chair with an identified PASD. The resident's medical conditions precluded the resident's physical or cognitive ability to release the PASD independently. Inspector #573 reviewed resident #002's written plan of care which identified the use of the PASD for resident #002's positioning while sitting in the wheel chair.

On January 05, 2018, Inspector #573 spoke with PSW #109 who indicated that the PASD for resident #002 was used for the resident's safety and positioning. Further, PSW #109 indicated that resident #015 was not physically capable of releasing the PASD independently.

On January 05, 2018, during an interview, RN #108 indicated that the PASD for resident #002 was used for the resident's safety and positioning. RN #108 indicated to the inspector that the PASD was not used to restrain the resident and indicated that it is used as a PASD. Further, RN #108 indicated that resident #002 was not cognitively and physically capable of releasing the PASD independently.

Inspector #573 reviewed resident #002's health care record with the RN #108 and noted that there was no consent that was obtained and documented regarding the use of the identified device as a PASD either from resident #002 or from the resident's SDM. [s. 33. (4) 4.]

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #025's substituted decision-maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of alleged, suspected or witnessed incident of abuse or neglect of the resident.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During a review of resident #005's health care record the Inspector discovered a progress note from an identified date, written by RN #116 describing an incident whereby resident #005 was observed rubbing resident #025's limb over the clothing while resident #025 was asleep. Resident #005's plan of care identified that resident #005 exhibits identified inappropriate behaviour of this type. The RN spoke with resident #005 to stop the behaviour, and informed the resident that the behaviour was not acceptable. The RN removed resident #005 away from the sleeping resident #025.

During an interview with Inspector #573 on January 10, 2018, RN #116 indicated that on an identified date, he/she observed resident #005 rubbing resident #025's limb over the clothing. The RN indicated that resident #005's behaviour towards resident #025 was inappropriate and sexual in nature. Further, the RN indicated that the act was non-consensual since resident #025 was sleeping. RN #116 indicated that he/she was the in-charge RN on the shift when the incident occurred. RN #116 indicated that he/she did not report the incident to the Director under the LTCHA, the home's DOC, or the Administrator.

During an interview with Inspector #573 on January 10, 2018, the DOC indicated to the Inspector that she was not aware of the incident on the above identified date. Further the DOC indicated to the Inspector that resident #025's substituted decision-maker, was not informed nor contacted regarding the incident.
(005628-17) [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is reported to the resident or the resident's substitute decision maker (SDM).

During a review by Inspector #178 of the home's record of medication incidents for the previous quarter, it was discovered that in two of three medication incidents reviewed, the resident or the resident's SDM was not informed of the medication incident.

Review of a Medication Incident Report for resident #006 indicated that on an identified date, the resident was not administered two identified medications as prescribed. The omission error was discovered by staff on the following shift. The resident was unharmed, the resident's physician was notified, and the resident's condition was monitored. The Medication Incident Report indicated that the pharmacy service provider and DOC were informed, but the resident or SDM were not notified.

Review of a Medication Incident Report for resident #005 indicated that on an identified date, the resident was not administered any of the resident's prescribed 0600 medications. The error was identified at 0900 by the nurse on the next shift and the medications were administered at that time. The Medication Incident Report indicated that the attending physician, the pharmacy service provider, and the DOC were notified, but the resident or SDM were not notified of the error.

During an interview with Inspector #178 on January 9, 2018, the home's DOC indicated that it is expected that nursing staff will notify the resident or SDM of any medication error or incident, and that there is a space on the home's Medication Incident Reports to document this notification. The DOC indicated that this requirement has been reinforced with nursing staff, and that further education regarding medication administration and medication audits will be provided by the home's pharmacy provider in the near future in response to these medication incidents. [s. 135. (1)]

Issued on this 21st day of February, 2018

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

Original report signed by the inspector.