Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_730593_0006	000838-20, 000842-20, 002305-20, 002306-20	Critical Incident System

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 10 - 11, 13, 18 - 19, 2020.

Log #000842-20 (2747-000001-20) was inspected related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.
Log #000838-20 (2747-000002-20) was inspected related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.
Log #002305-20 (2747-000004-20) was inspected related to alleged staff to resident abuse.
Log #002306-20 (2747-000005-20) was inspected related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), PSW Supervisor, Registered Nursing staff, Personal support workers (PSW's), housekeeping staff and residents.

The Inspector observed the provision of care and services to residents, resident to resident interactions, staff to resident interactions, residents' environment and reviewed resident health care records, investigation records and licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	Légende 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 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 a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to residents #003 and #004, has immediately reported the suspicion and the information upon which it was based to the Director.

A critical incident report (CIS) was submitted to the Director reporting the alleged physical abuse of resident #003. It was reported in the CIS, that during care, PSW #102 put a wash cloth over the resident's face. This was witnessed by PSW #103 who failed to report the incident until 13 days later.

A critical incident report (CIS) was submitted to the Director reporting the alleged physical abuse of resident #004. It was reported in the CIS, that resident #004 was wrapped up in a sheet by PSW #102, restraining their movement. It was also discovered that this was witnessed by PSW #103 who failed to report the incident until 13 days later.

During an interview with Inspector #593, February 13, 2020, PSW #103 indicated that they witnessed both incidents of alleged abuse by PSW #102 and that initially they did not go to the nurse because they did not feel comfortable. They added that it was bothering them the next few nights and so they went to their supervisor, PSW Supervisor #104. PSW #103 added that they had completed education on their duty to report and they were aware of the immediate reporting requirements when it came to allegations of resident abuse.

During an interview with Inspector #593, February 18, 2020, PSW Supervisor #104 indicated that the incidents were reported to them by PSW #103 13 days after the incidents occurred. The PSW Supervisor said that it was communicated to PSW #103 that the incident should have been reported immediately.

The home's investigation records were reviewed, and it was documented that the incident was brought forward by the PSW 13 days after the incidents occurred.

Two incidents of suspected resident abuse were witnessed by PSW #103. PSW #103 reported these incidents to their supervisor 13 days after they occurred. The CIS was submitted to the Director, the following day. As such, the licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, has immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 ensuring that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was not restrained, in any way, for the convenience of the staff.

A critical incident report (CIS) was submitted to the Director reporting the alleged physical abuse of resident #004. It was reported in the CIS, that resident #004 was

wrapped up in a sheet by PSW #102, restraining their movement. It was also discovered that this was witnessed by PSW #103 who reported the incident to their supervisor.

During the home's investigation, a second incident was brought forward by RN #105. It was reported by the RN that during the night shift, they found resident #004 with a draw sheet wrapped around their body, disallowing any movement of their left arm and hand. The sheet was brought up high under the resident's right arm, across their chest to beneath their chin and over their left shoulder, arm and hand tucked under their upper body. The RN further reported that it was obvious that, should resident #004 have wanted to use their left hand/arm or even just change their position, they would have been unable to do so. The RN found PSW #002 and told them that this was wrong and to attend to the resident immediately to remove the constrictions.

During an interview with Inspector #593, February 13, 2020, PSW #103 indicated they were assisting PSW #102 with care and was told that resident #004 needed assistance and to meet PSW #102 in their room in 15 minutes. PSW #103 said that they went to the resident's room early as they wanted to get the supplies set up for when PSW #102 arrived. PSW #103 found resident #004 wrapped to the neck in blankets and tucked in so hard without being able to move their arms as they were pinned by their side. PSW #103 said that PSW #102 arrived in the room and they asked PSW #102 what was going on, PSW #102 said that they did not want the resident exhibiting a particular responsive behaviour.

During an interview with Inspector #593, February 19, 2020, RN #105 indicated that towards the end of their night shift, they went to resident #004's room to check the resident. RN #105 said they found an extra white draw sheet beneath the resident on the right side, across their chest and securing their left arm extending down their body. RN #105 found PSW #102 and asked what they had done as the resident looked to be straight jacketed. RN #105 said that when speaking to PSW #102 about the incident at a later date, the PSW responded, I don't know how they wriggled themself into that. RN #105 said that there was no way the resident wriggled themselves into the sheet, as it was too perfect. RN #105 added that they believe PSW #102 did it because resident #004 is known to have responsive behaviours that can create additional work for PSW staff. RN #105 added that this was not the answer and that there are other things they can do to stay on top of this.

In a letter from the licensee to PSW #102, the following was written:

• The employer, acting on reports it received from multiple sources, undertook an investigation into incidents. During your shift on that date you left a resident bundled up so tight leaving the resident unable to move. This puts them at considerable risk of personal injury, and this also constitutes a restraint. I note that you were also advised by the Charge Nurse that bundling a resident in a “straight-jacket” was inappropriate.

On two occasions, it was witnessed that PSW #102 had resident #004 wrapped tightly in a sheet restricting movement and without the ability to free themselves. It was reported that this was done for the convenience of staff member #102 and as such, the licensee has failed to ensure that resident #004 was not restrained, in any way, for the convenience of the staff. [s. 30. (1) 1.]

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 ensuring that every licensee of a long-term care home shall ensure that no resident of the home is restrained, in any way, for the convenience of the licensee or the staff, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

A Critical Incident report (CIS) was submitted to the Director related to a critical incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. It was reported in the CIS that resident #002 sustained an unwitnessed fall, which resulted in a significant injury requiring medical intervention.

A review of resident #002's documented care plan showed the following:

• Transfers: two staff provide weight bearing assistance to come to standing position and provide non-weight bearing physical assistance such as guided maneuvering/steadiness to transfer.

On February 10, 2020 at 1502 hours, Inspector #593 observed the following:

• PSW #100 was observed in the room with resident #002. PSW #100 moved the wheelchair to the side of the bed and applied the brakes. Resident #002 was lying on the bed and PSW #100 had the resident sit up and sit on the side of the bed. While supporting the resident with one of their arms, PSW #100 had resident #002 stand and swivel and then sit in the wheelchair. At this time, a second PSW as well as RN #101 entered the room as the call bell had been activated. RN #101 left shortly after seeing that the resident was ok, the second PSW stayed and assisted the resident with care. The second PSW was then observed to take resident #002 out of the room.

During an interview with Inspector #593, February 10, 2020, PSW #100 indicated that they were aware that resident #002 was a two-person transfer.

During an interview with Inspector #593, February 10, 2020, the DOC confirmed that resident #002 was a two-person transfer.

The licensee has failed to ensure that resident #002 was transferred with two persons, as specified in the plan of care. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with r. 48. (1), Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, and 4. A pain management program to identify pain in residents and manage pain.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program", policy #VI-G-10.58, revision date February 2020, which is part of the home's falls prevention and management program and the licensee's "Pain and Symptom-Assessment and Management Protocol", policy #VI-G-70.00, revision date January 2016, which is part of the home's pain management program.

A Critical Incident report (CIS) was submitted to the Director related to a critical incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. It was reported in the CIS that resident #001 sustained an unwitnessed fall which resulted in a significant injury requiring medical intervention.

A review of the home's policy "Falls Prevention and Management Program", policy #VI-

G-10.58, revision date February 2020, found the following:

Post Falls Assessment- The Registered Staff will:

14. A Falls Risk Assessment will be done in Point Click Care if there has been any change in status and the care plan updated accordingly. The care plan must be individualized to meet the resident's needs.

The e-Assessments were reviewed for resident #001. There was no Falls Risk Assessment completed when the resident returned from hospital. The most recent Falls Risk Assessment completed was a month prior to this.

A review of the home's policy "Pain and Symptom- Assessment and Management Protocol", policy #VI-G-70.00, revision date January 2016, found the following:

Procedure:

The Registered Nurse/Registered Practical Nurse will:

1. Conduct and document a pain assessment in Point Click Care,

• On admission and re-admission.
• When a significant change of status or a change in condition with pain onset.
• When receiving prn pain medication for greater than 72 hours.

The e-Assessments were reviewed for resident #001. There was no Pain Assessment completed when the resident returned from hospital. The most recent Pain Assessment completed a month prior to this.

The following prn medication order was administered to the resident daily for five days following return from hospital:

• (pain medication- name removed)- take 2 tablets twice a day as needed.

Furthermore, according to the progress notes, resident #001 was complaining of pain to their injury site from the day they returned from hospital, and for at least two weeks post re-admission. The progress notes also indicated that the Physician, reviewed and modified (increased) previously ordered pain medication during this time period.

During an interview with Inspector #593, February 11, 2019, RN #101 indicated that after resident #001 returned to the home post- hospitalisation, the resident was frequently complaining of pain. They added that this is reported to the physician and the pain medications have been adjusted accordingly however they were not consistently re-doing the pain assessments, but they were trying to manage the resident's pain.

During an interview with Inspector #593, February 19, 2020, the DOC indicated that there was a checklist to complete when a resident returned from hospital and this included the assessments that needed to be completed.

After a fall resulting in a significant change in condition, a Falls Risk Assessment was not completed as per the policy. After returning from hospital with a change in condition resulting in pain onset as well as the use of prn pain medication for greater than 72 hours, a Pain Assessment was not completed as per the policy. As such, the licensee has failed to ensure that the required policies Falls Prevention and Management Program, and Pain and Symptom- Assessment and Management Protocol were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.