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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 4, 2023	
Inspection Number: 2023-1241-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Osgoode Care Centre	
Long Term Care Home and City: Osgoode Care Centre, Metcalfe	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.08.11 11:24:10 -04'00'
Additional Inspector(s) Anandraj Natarajan (573) Kelly Boisclair-Buffam (000724)	

INSPECTION SUMMARY

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

The following intakes were completed in this complaint inspection:
· Intake: #00017065 related to care concerns of resident

The following intakes were completed in this Critical Incident (CI) inspection:
· Intake: #00085790 - CI# 2747-000004-23, #00085789 - CI# 2747-000005-2 - Fall of residents resulting in injury
· Intake: #00088833 - CI # 2747-000009-23 - Responsive behaviour of resident

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

Falls Prevention and Management
Infection Prevention and Control
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours

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) (a)

The licensee failed to ensure that the resident's written plan of care set out the planned care for the resident specifically related to the use of the wander guard bracelet.

Rationale and Summary

The resident's health care records indicated that the resident exhibited responsive behaviors, including wandering behavior and exit seeking. The resident's nursing progress notes and an interview with a Registered Practical Nurse (RPN) identified that the resident wears a wander guard bracelet since their admission to the home. In April 2023, the resident exited a hallway near the dining room through an unlocked electromagnetic lock (maglock) door into a non-residential area of the home. The resident exited the non-residential area and went outside to the loading dock area and had a fall incident. At the time of the incident, the resident did not have the wander guard bracelet on them.

The resident's written plan of care at the time of the incident did not have any information related to the use of a wander guard bracelet. During an interview, an RPN indicated to the inspector that the wander guard might alert the staff when the resident went through the non-residential area maglock door. Furthermore, they indicated that the resident's written plan of care was updated with information related to the use of the wander guard bracelet after the incident in April 2023.

The failure to ensure the written plan of care set out the planned care for the resident related to the use of a wander guard bracelet places a potential risk to the resident's safety.

Sources: The resident's health care records, interview with RPN and other staff. [573]

WRITTEN NOTIFICATION: Plan of Care - Duty of licensee to comply with plan

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.

Rationale and Summary

The resident's chart in Point Click Care (PCC) show an order written for the resident dated March 2022 and June 2022 for weekly weights to be taken. In August 2022, weight order changed to twice weekly.

Review of resident's documentation confirmed that the weight order was not followed for one week in May 2022, three weeks in June 2022, one week in July 2022 and two times in August 2022 when the order was changed to twice weekly.

Interview with Dietitian confirmed that the resident's plan of care was updated with required weight checks for staff and anytime the order changed.

Interview with the DOC confirmed that the resident's weight orders were missed one week in May 2022, three weeks in June 2022, one week in July 2022 and two times in August 2022 when order was changed to twice weekly.

Failure to complete resident's weight as ordered resulted in risk of harm to resident as monitoring resident weight was part of the plan of care.

Sources: The resident's health care records, interview with Dietitian and DOC. [720492]

WRITTEN NOTIFICATION: Plan of care - Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, 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.

Rationale and Summary

The resident's plan of care indicated that the resident should have a tab alarm attached when in bed and wheelchair.

In November 2021, the incident report by an RPN recorded that the tab alarm did not sound as it was

found clipped onto flat sheet in resident's bed at time of fall.

An interview with the DOC confirmed that the incident report stated resident was found on the floor at the time of the fall, and that the tab alarm was not in place on the resident, but found in the resident's bed, which indicated that the intervention was not in place.

The licensee's failure to ensure that the intervention set out in the plan of care was in place resulted in potential delay in staff responding to the resident's fall. The risk was moderate as the resident was at high risk for falls and injury.

Sources: The resident's health care records, including plan of care, incident report, interview with DOC and others. [720492]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (1)

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is responded to and acknowledged within ten business days including what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Rationale and Summary

Meetings were held with the resident's substitute decision-maker (SDM) in November and December 2021 related to care concerns of a resident and complaints.

Interview with Administrator and DOC confirmed that meetings were conducted with the SDM in November and December 2021 and that no follow up email or letter was provided to the SDM as required.

Failure to follow up with the complainant puts the resident at risk, as investigation and follow up cannot be confirmed related to care concerns of the resident raised by complainant.

Sources: Record review of the resident including email and meeting communication, and interview with the Administrator and DOC. [720492]

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (2)

The licensee failed to ensure that a documented record is kept in the home as required.

Rationale and Summary

Meetings regarding resident care concerns and complaints were held with the resident's Substitute Decision Maker (SDM) in October 2021, November 2021, December 2021, February 2022, July 2022 and August 2022.

Interview with Administrator and DOC confirmed they do not have documented records of meetings with the SDM regarding resident care concerns and complaints.

Failure to keep a documented record of meetings related to care concerns of the resident resulted in no risk to the resident.

Sources: Record review of resident including SDM meeting summaries, and interview with Administrator and DOC. [720492]

WRITTEN NOTIFICATION: Complaints — reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 103 (1)

The licensee failed to ensure that written complaints with respect to improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall submit a copy of the complaint to the Director.

Rationale and Summary

The Administrator provided copy of letters in October 2021 and January 2022 received by SDM of a resident related to improper or incompetent treatment and care of the resident.

Interviews with the Administrator and DOC confirmed that the letters were not submitted to Director as required.

The risk of harm to resident is low as a result of this non-compliance as resident was not impacted.

Sources: Record review of the resident including letter received by resident's SDM, and interview with Administrator and DOC. [720492]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary

A review of a Critical Incident Report indicated that in April 2023, the resident had an unwitnessed fall with no evidence of injury at the time of the fall. Furthermore, the CIR indicated that the resident had increased pain, swelling, and limited range of motion in the right elbow. On the same day, the resident was transferred to the hospital for further assessment and was

During an interview, the DOC stated that the resident's fall incident resulted in a significant change in the resident's health condition. The Ministry of Long-Term Care's Director was informed four business days after the occurrence of the incident.

Sources: Critical Incident Report, resident's health care records, and interview with the DOC. [573]

WRITTEN NOTIFICATION: Safe and Secure Home - Doors in a home

NC #008 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

In April 2023, a resident exited a hallway near the dining room through an unlocked electromagnetic lock (maglock) door into a non-residential area of the home. The resident then exited the LTCH's non-residential area through an unlocked back door and went outside to the loading dock area. The resident had walked off the loading dock and had a fall into the pavement. The resident was transferred to the hospital for further assessment and returned to the home with no injuries.

During an interview, the Administrator indicated to the inspector that they suspected that the resident may have followed a staff member through the non-residential area maglock door which have a delay in relocking. Furthermore, they stated that after the incident the non-residential area maglock door was reset with a one to two-second delay on relocking.

The failure to ensure that the door leading to the non-residential area is kept closed and locked when not supervised by staff poses a potential risk to the residents safety.

Sources: Critical Incident Report, resident's health care records, and interview with the Administrator. [573]

WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Rationale and Summary

#1

Specifically, staff did not comply with the "Fall Prevention and Management", dated March 2022, which was included in the licensee's Falls Prevention and Management Program related to the Falls Incident Reports.

The Falls Prevention and Management policy, #VI-G-10.58, revised March 2022, page 2, under section

Post Falls Assessment, directed the registered staff to: "9. Complete the PCC Falls Incident Report."

Review of the resident's progress notes in Point Click Care (PCC) stated that resident had three falls on a night shift in August 2023, as charted by the Registered Nurse (RN).

Review of the resident's incident reports in PCC confirmed that one incident report was completed in August 2022 for all three of the resident's falls.

An RPN and RN confirmed that a separate incident report is required for each fall of a resident and that this was not done for the resident in August 2023.

#2

Specifically, staff did not comply with the "Fall Prevention and Management", dated March 2022, which was included in the licensee's Falls Prevention and Management Program related to the Head Injury Routine.

The Falls Prevention and Management policy, #VI-G-10.58, revised March 2022, page 2, under section Post Falls Assessment, directed the registered staff to: "7. Initiate a Head Injury Routine (VII-G-10.22) if: a. head injury is suspected b. if the resident fall is unwitnessed and resident is unable to describe the incident.

Review of the resident's progress notes and incident report in Point Click Care (PCC) confirmed that resident had three falls on a night shift in August 2023, and the resident was found by staff and the bed alarm sounded for all three falls.

Upon review of the resident's health care records including the hard copy of resident's chart, there were no Head Injury Routine's (HIR's) found for the resident for falls dated August 2023.

An RN confirmed that no HIR was completed for the resident in August 2023.

Sources: Falls Prevention and Management policy, #VI-G-10.58, revised March 2022, resident's health care records including progress notes, incident reports, hard copy of resident's chart, interviews with an RPN, RN and other staff. [720492]

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 (8)

As per O. Reg. s. 102. (8)
The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

The licensee failed to ensure that all staff participate in the implementation of the infection control program as recreation staff did not sanitized shared equipment during a group activity .

Rational and Summary

On a date in June 2023, Inspector #724 had observed a resident group activity that required sharing equipment. Recreational staff were observed not sanitizing their hands , not sanitizing the shared game piece or sanitizing the residents hands after each use.

Interview with the IPAC Lead, confirmed the practice for the recreation staff is to sanitize all shared equipment with Oxivir 1% before individual resident usage.

Interview with the Associate Administrator and Quality Resident Experience, concluded that the home's expectation for their recreation staff, was to sanitize all shared equipment in between resident usage and this procedure had been communicated to their staff .

A review of the IPAC Recreation Policy provided by the IPAC Lead , confirmed the homes' expectations.

As a result of not sanitizing resident shared equipment , the residents were at risk for cross contamination.

Sources: Inspector's observation, interview with staff and provided Recreation IPAC Policy. [000724]