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: December 21, 2023

Inspection Number: 2023-1241-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Osgoode Care Centre

Long Term Care Home and City: Osgoode Care Centre, Metcalfe

Lead Inspector	**Inspector Digital Signature**
Shevon Thompson (000731)	Shevon M Thompson Digitally signed by Shevon M Thompson Date: 2024.01.11 14:38:06 -05'00'

Additional Inspector(s)
Laurie Marshall (742466)
Saba Wardak (000732)

INSPECTION SUMMARY

Intake Details
The inspection occurred onsite on the following date(s): November 16, 17, 20, 21, 22, and 23, 2023.

The following intake(s) were inspected:
Intake: #00097402- Fall of resident resulting in significant injury.
Intake: #00097405 - Improper/Incompetent treatment of resident resulting in a fall.
Intake: #00097802 - Injury of resident resulting in significant change in condition.
Intake: #00099890 - Fall of a resident resulting in significant injury.
Intake: #00100403 - Fall of a resident resulting in significant injury.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued April 2022 and revised September 2023, section 10.1 the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Hand Rub (ABHR). Specifically, the licensee has failed to ensure that the hand hygiene agents being used were not expired.

Rationale and Summary:
On November 16, 2023, during an observation on a unit in the home a hand sanitizer, was noted with an expiration date of April 24, 2022. A second hand sanitizer with the same expiration date was noted, in the hallway of the same unit, on a utility cart. The Director of Care (DOC) confirmed the expired hand sanitizers were being used but stated they would be removed. The expired hand sanitizers were not observed to be used by either staff or residents.
During an observation, on the same unit, on November 20, 2023, no expired hand sanitizer was noted.

Sources: Observations, interview with the DOC, [000731]

Date Remedy Implemented: November 20, 2023

WRITTEN NOTIFICATION: PASD- When a PASD may be used

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
When PASD may be used
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee has failed to ensure that the Personal Assistive Services Device (PASD) used to assist a resident with activities of living was included in the plan of care.

Rationale and Summary:
Review of the homes policy (November 2023, #VI-G-10.60) Use of Assist devices identified that:
4- Use of assist devices are to be documented in the resident's plan of care,
#5. The use of/need for assist devices will be reviewed during the quarterly RAI/MDS assessment (section G) and the plan of care will be reviewed and updated with any required changes.

The plan of care did not identify that the resident had assistive devices in place.

Review of the homes Resident Assessment Instrument - Minimum Data Sets (RAI-MDS) quarterly assessment did not indicate that the resident used assistive device for bed mobility or transfers.

Staff reported that the resident used an assistive device while in bed for repositioning and turning.

Interview with the Assistant Director of Care (ADOC) confirmed that assistive devices were not included in the plan of care for resident.

There was a potential risk for injury because the licensee failed to identify the use of these devices as a PASD to assist with activities of living in the plan of care for the resident.

Sources: Policy (November 2023, #VI-G-10.60), plan of care, RAI-MDS quarterly

assessment; interview with staff and ADOC. [742466]

WRITTEN NOTIFICATION: PASD- Inclusion in the plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4)
PASDs that limit or inhibit movement
Inclusion in plan of care
s. 36 (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.
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.
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.
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.
5. The plan of care provides for everything required under subsection (5).

The licensee has failed to ensure the satisfaction of all the requirements under 36 (4) of the Act for the use of a Personal Assistive Services Device (PASD) for assistance in the activities of living for the resident.

Rationale and Summary:
As per paragraph 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.

Review of the resident's RAI-MDS quarterly assessment did not indicate that the resident used assistive devices for bed mobility or transfer.

Interview with staff reported that these devices were not identified as PASD.

Interview with the Assistant Director of Care (ADOC) confirmed that no other alternatives had been considered instead of these devices to assist the resident with activities of daily living when in bed.

Interview with the Director of Care (DOC) reported that once the devices were applied they were not assessed and the DOC was not able to confirm if there was an assessment for the use of these devices to assist the resident with activities of living.

As per paragraph 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.

Review of the resident's RAI-MDS quarterly assessment did not indicate that the resident used these devices for activity of daily living.

Interview with staff reported that the resident used the devices to assist with activities of daily living and that the devices were was necessary to effectively assist the resident with activities of daily living.

As per paragraph 3, the use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Record review of the resident's physical chart and electronic chart did not contain approval by a physician, registered staff, physiotherapy or occupational therapist or identified the devices for PASD use as part of the resident's plan of care.

The homes policy (VII-F-10.09, October 2022) Personal Assistive Device (PASD) indicated that: 3. The use of the PASD has been approved by one of the following,

a) a physician,

b) a registered nurse,

c) a registered practical nurse,

d) a member of the College of Occupational Therapists of Ontario,

e) a member of the College of Physiotherapists of Ontario, or

f) any other person provided for in the regulations.

In an interview with staff it was reported that the use of the devices would only be documented in the plan of care if there was a request from family or physiotherapy.

Interview with the ADOC confirmed that there was no consent process for implementing these devices as the home did not view these devices as a PASD.

As per paragraph 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.

A record review of the resident's physical chart and electronic chart did not contain a consent signed by the Substitute Decision Maker (SDM) for the resident regarding the use of a PASD or these devices.

The homes policy (VII-F-10.09, October 2022) Personal Assistive Device (PASD) indicated that: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a SDM of the resident with authority to give that consent.

Interview with the ADOC confirmed that there was no consent process for implementing these devices as the home did not view them as PASDs.

Interview with the DOC reported that the devices were used as an assistive device for the resident but did not consider the devices as PASDs and consent was not required.

As per paragraph 5, the plan of care provides for everything required under subsection (5).

Review of resident's plan of care did not include the use of a PASD for activities of

daily living.

Interview with the ADOC confirmed that the devices should have been identified in the plan of care for the resident as they were used for activities of daily living.

The licensee failed to satisfy all of the requirements for the use of a a specific devise as a PASD for the resident, which increased their risk for injury.

Sources: Resident physical chart and electronic chart, policy (VII-F-10.09, October 2022) Personal Assistive Device (PASD); Interview with staff, ADOC, DOC. [742466]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), 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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with. Specifically, the licensee has failed to initiate and complete head injury routines

(HIR) for two residents. Additionally, the licensee has failed to ensure the completion of a Post Fall Observation following one resident's unwitnessed fall.

Rationale and Summary:
#1
In a review of the resident's chart, inspector was unable to find a HIR initiated for the resident's fall.

A review of the head Injury routine initiated for the resident's fall indicated the resident was assessed twice. There were no further assessments documented to meet the time requirements for HIR according to the home's policy.

In an interview with staff, they stated that the head injury routine was to be completed when a resident had an unwitnessed fall. Based on a staff's review of the documentation for the fall, the staff validated that the fall would be considered unwitnessed and confirmed that a head injury routine had not been initiated.

The Falls lead affirmed that a head injury routine was to be initiated for all unwitnessed falls. After a review of the progress note for the resident's fall, the Falls lead validated that a head injury routine should have been completed as the fall was unwitnessed. After a review of the HIR for the resident's fall the Falls lead affirmed that based on the home's policy, the HIR should not have been stopped at that time.

Failure to ensure that the fall prevention and management program is complied with places the residents at an increased risk for any changes in their condition to go unnoticed and untreated.

Sources: resident electronic health record, interview with staff and Falls lead, [000731]

#2
Specifically, staff did not comply with the Falls Prevention and Management Policy, revised March 2023, 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 2023, page 2, under Post Falls Assessment, directed the registered staff to: "Monitor Head Injury Routine: check vital signs every hour for 4 hours, then every 4 hours for 24 hours"

The resident had an unwitnessed fall. A review of the resident's progress notes and risk management reports in Point Click Care (PCC) confirmed that the resident was found on the floor following the incident and was unable to recall the events leading up to the fall. Progress notes also confirmed that the resident had a change in behaviours at the time of the fall.

Upon review of the resident's health care records including the hard copy of resident's chart, Head Injury Routine (HIR) assessments were not completed on two occasions following the resident's unwitnessed fall. Documentation for HIR was completed on the physical paper chart for the first 4 hours following the unwitnessed fall. Documentation for HIR assessment was not completed for all require times following the incident.

The DOC confirmed that HIR assessments should have been completed and documented at additional times. The Falls Lead, also confirmed that as per the home's policy, HIR assessments should be completed for 24 hours following an unwitnessed fall, however, registered staff did not perform HIR on all occasions following the resident's unwitnessed fall.

#3
Specifically, staff did not comply with the Falls Prevention and Management Policy, revised March 2023, which was included in the licensee's Falls Prevention and Management Program related to Post Falls Assessment.

The Falls Prevention and Management Policy, #VI-G-10.58, revised March 2023, page 2, under section Post Falls Assessment, directed the registered staff: "assessment for any potential injury will be done for a minimum of three consecutive shifts and documented."

On a specific date, a resident had a fall. Upon review of the resident's health care records including the hard copy of the resident's chart, a post fall assessment was not completed on one occasion following the resident's fall. The DOC and Falls Lead confirmed that a post fall assessment was not completed on one shift following the resident's fall.

Sources: Falls Prevention and Management Policy, #VI-G-10.58, revised March 2023, resident's electronic health records including progress notes, risk management, incident report and medication administration records, interviews with the DOC and Falls Lead. [000732]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted

using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:
A review of the resident's progress notes indicated the resident had fallen on on two specific date. Upon further review of the resident's health care record inspector was unable to find a completed post fall assessment instrument clinically designed for falls that had been used to assess the resident after either fall. Registered staff was unable to identify a post-fall assessment that was completed using a clinically appropriate assessment instrument specifically designed for falls. The Falls lead confirmed that there was no clinically appropriate post fall assessment tool, specifically designed for falls being used in the home.

Failure to complete a post fall assessment, using a clinically appropriate assessment instrument specifically designed for falls, may delay determining the cause of the fall and implementing any necessary post fall interventions.

Sources: resident's progress notes, interview with registered staff and Falls lead. [000731]

COMPLIANCE ORDER CO #001 Plan of care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

Duty of licensee to comply with plan
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:
The licensee shall:

a. Provide training to a staff related to reviewing residents the plan of care/kardex for their assigned residents prior to the start of their shift.

b. Perform audits on a staff three times per week for three weeks to ensure that they are reviewing and following plan of care/kardex including adhering to falls prevention management.

c. Document the audits and corrective actions taken based on audit results.

A written record must be kept of everything required under step (a), (b) and (c) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan specifically related to specific device. The resident had a fall from a device which was not in the position required in the plan of care resulting in an injury.

Rationale and Summary:

Review of the Fall Risk assessment for the resident identified that assessments previously conducted identified the resident as a high falls risk.

The care plan for the resident identified that resident was a high falls risk and when a specific device was in used it to be at in a specific position that would mitigate the risk of injury if a fall occurred.

The progress notes and incident report indicated that the resident was left unattended while on a device after a staff had elevated the device. During that time the resident fell from the device onto the floor. The incident report indicated that the device was at an unsafe height when the resident fell. This information was confirmed during the homes investigation in an email sent by a staff indicating that they had left the resident unattended while the device had been elevated to a working height position.

Interview with staff reported that the resident fell from the device during the time the staff left the resident unattended with the device elevated. Staff reported that they measured the height of the device post fall iand determined that the device was at at an elevated height when the resident fell.

Interview with the DOC confirmed that the resident fell from a an elevated height, which was at a working height for staff.

As a result failure to ensure that the care set out in the plan of care, specifically related to safe height of device for the resident, the resident had a fall causing significant injury.

Sources: Resident's Fall Risk Assessment, progress notes, care plan, email from staff, Interviews with staff, and DOC .

[742466

This order must be complied with by February 1, 2024

COMPLIANCE ORDER CO #002 Bedrails

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with s. 18 (1) (a) of the FLTCA.

Specifically, the licensee shall ensure:
a. The licensee will conduct and document assessments including a risk-benefit assessment for residents with bedrails in accordance with the homes bedrail policies; and

b. The written plan of care for each resident with bedrails, is based on an assessment of the resident providing clear directions to staff as it relates to the use of bedrails.

c. A written record must be kept of everything required under step (a) and (b) of this

compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the resident was assessed for bedrail use including the risk of entrapment in accordance with prevailing practices as per the memo "Use of Bedrails in Long-Term Care Homes" provided to all licensees from the Director, August 2023.

Rationale and Summary:

Progress notes from admission in 2022 indicated that the resident had a quarter bedrail.

At the time of the incident, when the resident sustained a fall from their bed resulting in injury, the progress notes and incident fall notes did not include quarter bedrails in the documentation.

The RAI-MDS quarterly review for the resident did not include bedrail use for bed mobility or transfers.

Review of the plan of care for the resident at time of the incident did not identify quarter bedrail use to assist with activities of living.

Review of the homes policy (November 2023, #VI-G-10.60) Use of Assist Rails identified that:
4- Use of assist rails are to be documented in the resident's plan of care under:
Focus- I require assistance with my daily care related to
New approach- bed mobility

#5. The use of/need for assist rails will be reviewed during the quarterly RAI/MDS assessment (section G) and the plan of care will be reviewed and updated with any required changes.

Staff confirmed that the quarter bedrail for the resident was used to help with bed mobility during care.

Staff reported that quarter bedrails are not followed up and that they are not put into the plan of care. Staff reported that the quarter rail was used to assist with turning in bed for repositioning or while during care of the resident.

Staff reported that the resident had two quarter bedrails and the night the resident was found on the floor only the quarter bedrail was up on the right side of the bed, which was the side they fell. Staff confirmed that quarter bedrails are to be considered as a PASD and are supposed to be assessed by Physiotherapy (PT) or Occupational Therapy (OT).

Record review of resident health record did not show that bedrails were assessed by PT or OT.

The Director of Care (DOC) reported that the quarter bedrail was used as an assistive device but did not consider an assist rail a PASD or a bedrail. The DOC stated that consent was not required for an assist rail nor was the DOC able to determine if the resident was assessed for a quarter bedrail. The DOC indicated that a quarter bedrail was used for assistance with activities of living for bed mobility and transfers for the resident. The DOC stated that once a a quarter bedrail is applied, it is not usually reassessed.

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As such, the resident was not assessed in accordance with prevailing practices or

the homes policy for bedrail use which increased their risk for injury.

Sources: Progress note, incident fall notes, RAI-MDS, plan of care, policy (November 2023, #VI-G-10.60) The Use of Assist Rails , interview with staff and DOC.
[742466]

This order must be complied with by February 1, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.