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: February 29, 2024

Inspection Number: 2024-1241-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Osgoode Care Centre

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

Lead Inspector	**Inspector Digital Signature**
Laurie Marshall (742466)	Laurie R Marshall Digitally signed by Laurie R Marshall Date: 2024.03.14 14:03:54 -04'00'

Additional Inspector(s)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 7, 8, 9, 12, 13, 2024

- Intake: #00101334 [CI:2747-000023-23]: Fall of a resident resulting in injury and significant change in condition.
- Intakes: #00105884 [CI:2747-000001-24]; #00107737 [CI:2747-000003-24]: Late reporting of declared outbreaks.
- Intake: #00105932 [CI: 2747-000002-24]: Improper/Incompetent treatment of a resident.
- Intake: #00104744 - Follow-up to compliance order #001 from inspection #2023_1241_0005 related to FLTCA, 2021 s. 6 (7)

- Intake: #00104745 - Follow-up to compliance order #002 from inspection #2023_1241_0005 related to O. Reg. 246/22 s. 18 (1) (a)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1241-0005 related to FLTCA, 2021, s. 6 (7) inspected by Laurie Marshall (742466)

Order #002 from Inspection #2023-1241-0005 related to O. Reg. 246/22, s. 18 (1) (a) inspected by Laurie Marshall (742466)

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

WRITTEN NOTIFICATION: Restraining by physical devices

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 35 (1)

Restraining by physical devices

s. 35 (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 34 (1) if the restraining of the resident is included in the resident's plan of care.

The licensee has failed to ensure that when a resident was restrained by a physical device as described in paragraph 3 of subsection 34 (1), the restraining of the resident was included in the resident's plan of care.

Rationale and Summary:
In a review of the resident's physical chart, the inspector noted that there was no order from a physician, registered nurse in the extended class or other person provided for in the regulations approving the use of a physical device as a restraint for this resident. Nor was there a consent noted for the use of this physical device as a restraint.

A review of the resident's plan of care revealed no noted intervention for the physical device to be tilted to keep the resident from falling.

In a review of the resident's Kardex inspector noted there was no intervention for the use of an physical device to prevent the resident from falling.

In an interview with a Registered Practical Nurse (RPN) they confirmed that the resident was at high risk for falls and that a falls prevention intervention used for the resident was to place the resident in a physical device which would be tilted back to prevent them from getting out by themselves. The RPN acknowledged that they were aware they were not supposed to do this but affirmed that the resident Substitute Decision Maker (SDM) agreed with this intervention.

The Assistant Director of Care (ADOC) confirmed that the resident had a physical device that they could transfer themself from but this was not safe. They were uncertain if the use of the physical device was in the plan of care or if there was consent for the physical device to be tilted. However, they verified that when a restraint is being used for a resident a consent needed to be obtained from the SDM and it needed to be added to the resident's plan of care. Following the interview ADOC reviewed the resident plan of care and confirmed that the use of a physical device was not in the resident's plan of care.

Failure to ensure that when the resident was restrained by a physical device as described in paragraph 3 of subsection 34 (1), the restraining of the resident was included in the resident's plan of care, places the resident at increase risk of injury.

Sources: review of the resident physical chart, electronic health record, interview with RPN and ADOC.
[000731]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is

immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that Director was immediately informed of outbreaks of diseases of public health significance on November 27, 2023, December 29, 2023 and January 15, 2024.

Rationale and Summary
Review of three Critical Incidents (CI) submitted by the licensee identified that:
1) Acute Respiratory Illness (ARI) was declared on November 27, 2023 and reported on December 4, 2023 [CI:2724-000024-23].
2) ARI - Influenza A outbreak was declared on December 29, 2023 and reported on January 5, 2024 [CI:2747-000001-24].
3) Enteric outbreak was declared on January 15, 2024 and was reported January 28, 2024 [CI:2747-000003-24].

During an interview with the Director of Care (DOC), they confirmed that outbreaks were not reported immediately and did not consider outbreak reporting to the ministry as a critical incident.

The licensee failed to immediately report to the Director on three occasions that outbreaks of diseases of public health significance were declared.

Sources: CI's; Interview with DOC. [742466]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

a. Review and revise the Infection Prevention and Control (IPAC) policy to comply with the IPAC Standard for Long-Term Care Homes section 9.1 (e) requirements of ensuring point-of-care signage indicating that enhanced IPAC control measures are in place for residents whom have been identified as requiring enhanced IPAC precautions.

b. Revise the resident hand hygiene policy to comply with IPAC Standard (IPAC) Standard for Long-Term Care Homes section 10.2 (c).

c. Provide education to all care staff and registered staff related to in the IPAC policy regarding point-of-care signage and resident's hand hygiene.

d. Complete resident hand hygiene audits for one meal service two times per week

on each resident home area (RHA). Audits to be completed on separate days, alternating between different mealtimes for 4 weeks.

e. A written record must be kept of everything required under step (a), (b), (c) and (d) of this compliance order, and shall include a copy of the training provided, those who attended with dates/times, as well as the name of the person who provided the training and must be kept for the requirements 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

#1

The licensee has failed to ensure that the Standard issued by the Director with respect to infection prevention control regarding point of care signage indicating that control measures were in place was complied.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, indicated that additional requirements under the standard 9.1 that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

The licensee used red dots on resident name plates to indicate which residents were on enhanced precautions.

Inspector #000731 observed a red dot on a resident's name plate. Two staff were seen in the room with the resident wearing gloves and mask.

Inspector #742466 observed that there were resident name plates that had red dots who resided on multiple home areas.

A list for residents on enhanced precautions was obtained and the observed resident was identified on the list for enhanced precautions.

A Registered Nurse (RN) reported that residents who are identified on enhanced precautions have a dot on their name plate to indicate that they are on enhanced precautions and there is no signage posted indicating enhanced precautions.

During an interview with a Personal Support Worker (PSW), the PSW required clarification from a registered staff about the purpose of the red dots when asked by inspector #742466.

Inspector #00731 interviewed another PSW, who was leaving the room for the resident on contact precautions. The PSW reported that the red dot was put up when the resident was on isolation, but they had forgotten to remove it. The PSW at this time was observed by inspector #000731 to remove the red dot off of the name plate for the resident.

The Assistant Director of Care (ADOC) reported that placing enhanced precaution signage up on residents doors would lead to staff donning gowns and gloves every time they entered that residents room when it was not always required and staff should be doing a risk assessment and ensure that gloves are worn at all times for care.

As such, staff were not alerted to additional precautions using point-of-care signage to indicate that enhanced IPAC control measures were in place therefore increasing

the risk of disease transmission between staff and residents.

Sources: Observations, List of residents on enhanced precautions, interview with PSW's, RN and ADOC. [742466]

#2
The licensee has failed to ensure compliance with any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure compliance with section 10.2 (c) of the IPAC Standard for Long-Term Care Homes that residents were provided assistance to perform hand hygiene before meals and snacks.

Rationale and Summary:
During an observation of the lunch meal in a home area dining room, inspector noted that four independent residents entered the dining room with no hand hygiene assistance offered to any of the residents. At meal service, one residents was assisted by a staff member into the dining area and no hand hygiene was offered to the resident. Shortly after, another resident was brought into the dining area by a staff and no hand hygiene was offered. In total, six residents came into the dining room with no offer or assistance with hand hygiene provided by staff for the lunch meal.

In an interview with a Personal Support Worker (PSW), they confirmed that residents are to be assisted with hand hygiene upon entering the dining room. They verified that independent residents were able to perform their own hand hygiene, or the staff were to provide the Alcohol Based Hand Rub (ABHR) to them before they sat at the table. They confirmed that it was the staff's responsibility to assist the residents with hand hygiene or to provide the residents with the ABHR.

A resident stated that assistance with hand hygiene was not offered to them on entering the dining room.

During an interview with a PSW, they stated that staff were required to assist residents with hand hygiene anytime they were going to eat and whenever their hands were visibly soiled. They verified that staff are expected to assist residents with the use of ABHR or to wash their hands.

In an interview conducted by Inspector #742466 with a Registered Nurse (RN), the RN confirmed that the home's hand hygiene program included resident's assistance with hand hygiene. They verified that staff were required to offer assistance to the residents to perform hand hygiene before and after meals.

By not providing assistance to residents to perform hand hygiene prior to meals, residents were placed at an increased risk of contracting and transmitting infectious pathogens.

Sources: observation of a home area dining room, Interviews with PSW's, RN and a resident. [000731]

This order must be complied with by April 25, 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.