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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2015	2015_287548_0016	O-002287-15	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

ROSEBRIDGE MANOR
131 Roses Bridge Road R. R. #2 Jasper ON K0G 1G0

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

RUZICA SUBOTIC-HOWELL (548), AMANDA NIXON (148), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 20,21, 22,23,24, 27,28,29,30,31,2015

Concurrently Logs#: O-002511-15, O-001330-14, O-001958-15 and O-002385-15 were inspected. During the course of the inspection, the inspector(s) toured resident care areas and non-residential areas, reviewed residents' health care records, reviewed infection control policies, environmental services procedures and policies, reviewed menus, zero tolerance of abuse and neglect policy, pain management protocol program, fall prevention program,
skin and wound program, resident-staff communication and response system, observed residents meal service andobserved medication administration.

During the course of the inspection, the inspector(s) spoke with the Residents, and Family Members, Administrator, Director of Care (DOC), Clinical Care Coordinator, Nursing Services Administration Manager, Environmental Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers((PSW) Health Care Aids (HCA) and Nursing Aides (NA)), Housekeepers (HSKP), Food Service Workers (FSWs), President of the Resident's Council and President of the Family Council.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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	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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On July 20, 2015, during the initial tour of the home, Inspector #148 observed there to be no visible resident-staff communication and response system in the large dining room, small dining/activity room or the central common area near the entrance of the home. During the meal service observation on the same date, Inspector #148 spoke with PSWs, FSWs and the home's Environmental Services Manager, who identified there to be no call bell located in the identified areas. Each of the three areas identified above were observed over the course of the inspection to be used for meal service, activities and/or gathering spaces.

Inspector #148 spoke with the home's Administrator regarding the lack of a resident-staff communication and response system in these areas. She indicated that she is aware of the need to have a communication system in areas accessible to residents, and has likely become aware of this over the course of this year as other LTC homes owned by the same licensee are having this issue identified by MOHLTC Inspectors. She is not aware of plans, at this time, to ensure a communication system is available in these areas.
[s.17.(1) (e)] (148)

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 is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #6, who is identified by the plan of care to be at risk of falls, had a fall in June and in July 2015, both related to the resident attempting to self-ambulate. The fall of June 2015, resulted in injury, whereby the mobility of the resident changed. RN #105 indicated to Inspector #148 that the resident remains at risk for falls as he/she attempts to raise out of the wheelchair, unassisted.

The home has a clinically appropriate assessment, as indicated by the DOC,titled Post Fall Investigation Assessment. In speaking with both RN #105 and the home's DOC, it was reported that this tool is to be completed after each fall in the home.

The health care record was reviewed and no post fall assessment was conducted using a clinically appropriate assessment instrument, specifically in relation to the fall of June 2015, whereby the condition of the resident would have required such assessment. [s.49 (2)] (148)

2. On July 20, 2015 S#119 Registered Nurse reported to Inspector #548 that Resident #37 had a recent fall.

The health record was reviewed and it was recorded that the resident had two falls, one in July 2015 and another in June 2015. For each incident the resident was found at the bedside.

On July 28, 2015 during an interview the DOC indicated that the home's process for all fall incidents includes the completion of a Post Fall Investigation Assessment, a tool specifically designed for falls. The DOC confirmed that the post–fall assessments were not completed for the two falls, as required and that she has become aware of a gap in the home's processes for post-fall assessments. [s.49 (2)] (548)

3. Additionally, Resident #44 fell in June 2015 and in July 2015. The electronic and hard copy health care record was reviewed by inspector #548. No post-fall assessment was conducted using a clinically appropriate assessment instrument as per the home's requirements.(Log#: O-002511-15). [s.49 (2)] (126)

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 where the condition or circumstances of the resident require a post-fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his/her personal needs.

On July 23, 2015, while Inspector #148 was walking down the East hallway, the Inspector observed Resident #43 to be in the tub room seated on the tub chair without clothes on and visible to passersby in the hallway. The Inspector immediately knocked on the door and informed PSW #S100, who was providing care, that the door would be closed by the Inspector as the PSW was not within arm's reach of the door. It was noted that the home's Clinical Care Coordinator passed the tub door just prior to the Inspector, but reported having not observed the door to be open. The Inspector spoke to PSW #S100 when the bath was completed; the PSW reported that the resident is undressed and transferred to the tub chair while in his/her room. The resident is then covered with a hospital gown and blankets and then taken to the tub room, where staff remove the gown and blankets and proceed with bathing. Inspector #148 confirmed with the PSW that she proceeded to undress the resident fully, prior to ensuring the residents privacy; the PSW agreed and indicated this was not her usual practice. [s.3.(1) 8.] (148)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that a plan of care must be based on, at a minimum, an interdisciplinary assessment of the following with the respect to the resident. Dental and oral status, including oral hygiene.

On July 21, 2015 Resident #28 indicated to Inspector #548 that he/she has a partial dental plate and removed it to show the Inspector. Inspector #548 observed the dental plate to be full of debris.

A recent Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessment indicated that Resident #28 required daily cleaning of teeth/dentures or daily mouth care by resident or staff.

On July 24, 2015 during an interview with both S#114 PSW and S#115 PSW whom indicated that the resident would refuse oral care at times and would need to be re-approached. S#106 RAI coordinator indicated that oral care is not care planned as the resident can determine whether to do it or not.

Upon record review of the resident's current care plan there are no identified care interventions for oral hygiene. [s. 26.(3) 12.](548)

2. On July 21, 2015 Inspector #548 observed Resident #31 to have debris to the bottom front row of teeth. The same was observed on July 24, 2015.

A recent Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessment indicated that Resident #31 required daily cleaning of teeth/dentures or daily mouth care by resident or staff.

On July 24, 2015 during an interview Resident #31 indicated that he/she brushes their own teeth twice a day and does not ask for any assistance.

July 27, 2015 during an interview S#112 RPN indicated that the resident does not require assistance for dental/oral care. S#112 indicated that the resident will brush his/her bottom teeth and staff will clean the resident's upper denture.S#113 PSW indicated that she was not sure what the care plan indicated for oral hygiene however, she does provide the resident a mouth swab. She indicated the resident will swab his/her own mouth prior to the insertion of the upper denture.

Upon review of the resident's current care plan there are no identified care interventions for oral hygiene. [s. 26.(3) 12.](548)

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section LTCHA, 2007, S.O. 2007, c.8, s.31.

On specified day in July 2015 Inspector #548 observed Resident #37 to be seated in a tilt wheelchair with a lap belt applied.

One week later the Inspector #548 observed Resident #37 to be seated in tilt wheelchair with the lap belt applied. Upon request of the inspector #548 the resident was unable to undo the lap belt.

On July 28, 2015 during an interview both S#118 PSW and S#105 RN indicated that the resident requires the lap belt to prevent him/her from falling out of the chair and hurting himself/herself. Both indicated that the resident is prone to shifting and moving to the edge of the wheelchair seat.

Subsequently, S#119 Charge RN indicated that the home's process for restraints includes a consent from the resident/POA and a physician's order.

The health care record was reviewed and there was no physician's order or consent found. This was confirmed by S#119 Charge RN.

On July 28, 2015 during an interview with S#106 RAI Coordinator he indicated that the Resident #37 has been assessed and has no need for the lap belt. S#106 with the inspector observed Resident #37 to be seated in the tilt wheelchair with the lap belt applied. S#106 proceeded to remove the lap belt. [s. 31 (1)](548)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #6 requires assistance with personal care. On July 21, 2015, the resident was observed by Inspector #148 to have heavy amounts of dark debris under finger nails and long facial hair on the chin. The resident was subsequently observed on July 27, 2015, to have the hairs on his/her chin trimmed; the resident's nails appeared to have been cared for with some darkened debris still present. The resident is schedule for evening bathing. PSW #117, who works primarily on evening shift, reported that the resident does not present any behaviours during care and is accepting of personal care and grooming. PSW #117 indicated that nail and facial care is completed during each bath and as needed.

Flow sheets for July 2015 were reviewed and indicate that nail and facial care were provided at a time after the Inspector's initial observation. Neither type of care was documented as provided July 1-20th, 2015. The resident's plan of care indicates the resident will be kept neat and clean with no specific directions related to nail or facial care.

Observations of July 21, 2015, indicate that personal care was not provided as needed to ensure Resident #6 was kept neat and clean.[s.32.](148)

2. On July 21, 2015 Resident #37 was observed by Inspector #548 to have short chin hair. The resident's chin was subsequently observed on July 28, 2015 to be covered in long chin hair.

On July 28, 2015 during an interview S#118 PSW indicated that the resident tolerates the removal of chin hair by staff and this is completed on bath days. The resident was scheduled to receive a bath on the evening of July 27, 2015.

The resident's care plan indicates that the resident will be kept neat and clean with no specific directions related to nail or facial care.

Observations and record review from July 21, 2015 and July 28, 2015 indicate that personal care was not provided as needed to ensure that Resident #37 was kept neat and clean. [s.32.](548)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that each resident of the home is bathed (includes tub baths, showers and full body sponge baths), at a minimum, twice a week by the method of his or her choice.

On July 21, 2015 Inspector #548 noted a body odor emanating from Resident #40. Due to the resident's physical limitations the resident's care plan specifies that extensive assistance from staff is required for the resident to remain clean, neat and free of body odors.

On July 23, 2014 during an interview with Inspector #548 S#100 PSW indicated that the resident is provided extensive assistance with bathing.

S#103 indicated that should a resident not receive their bath as scheduled that all attempts are made to complete the bath the following day. Resident #40 is scheduled to have a shower twice a week.

The home's flow sheets indicated that on specified day in July 2015 a shower did not occur. It is also recorded that a shower was not provided for the following two days and on the next scheduled bath day. Whereas, there is documentation that the resident received a bath/shower/bedbath as scheduled the following week.

On July 23, 2015 Inspector #548 observed Resident #40 to be odor-free. Upon record review of the PSW Observational Flow Sheet it is recorded and initialed by staff that the resident received a shower the previous evening. [s. 33. (1)](548)

2.Resident #6 requires assistance with bathing and was observed by Inspector #148 on July 21, 2015, with hygiene and grooming concerns. The Inspector reviewed the home's bathing schedule and the resident's flow sheets. The resident is scheduled for evening baths, twice a week. The flow sheets support that bathing was not provided twice a week as scheduled on a specified date in July 2015; indicating that the resident was not provided bathing for a span of 6 days. The health care record did not support refusal of bathing during the time frame specified and staff reported the resident as accepting of bathing care. [s. 33.(1)](148)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee has failed to ensure that each resident admitted to the home must be screened for tuberculosis (TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #2 was admitted to the home on a specified date in early 2015. The resident's health care record was reviewed by Inspector #148 and later by the home's DOC. It was determined that the resident was provided a TB screen by x-ray in the early fall of 2014. Screening for TB was not conducted within 14 days of admission or 90 days prior to admission.

Resident #31 was admitted on a specified date in early 2015. The resident's health care record was reviewed by Inspector #148 and later by the home's DOC. It was determined that although an admission note by the DOC indicates that screening had been completed prior to admission, documented results of this screening were not available. [s229.(10) 1.] (148)

Issued on this 10th day of August, 2015

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

Original report signed by the inspector.