Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 20, 2018	2018_702197_0006	000244-18, 003435-18	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

JESSICA PATTISON (197)

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): March 7, 8, 2018

The following logs were inspected as part of this report:
Log #'s 000244-18 and 003435-18 - both related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nursing Administrative Services Manger, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Housekeeping staff member and a resident.

The inspector also reviewed two internal investigation files, a human resources file, abuse education records and the licensee's prevention of abuse policy.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 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 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 :

The following finding is related to log 000244-18:

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper treatment and/or abuse of a resident, did not immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, resident #002 rang the call bell for assistance. RN #100 entered the room to provide care. According to the Critical Incident Report, RN #100 alleged that resident #002 became upset when the staff member moved the resident's call bell and became physically violent with the staff member. RN #100 obtained an order for a particular medication and requested the assistance of PSW staff while giving the the specified medication to resident #002.

Resident #002 was interviewed by the inspector and indicated that a nurse had assaulted them. The resident said this nurse wrapped their arms around the resident's head. At the time of the interview the resident could not recall the name of the staff member. Resident #002 was asked if this same nurse gave them a medication. Resident #002 responded by saying that yes, the nurse had people hold them down to give a medication.

PSW #101 confirmed during an interview that they worked the day this incident occurred

with resident #002. This staff member stated that RN #100 inappropriately administered the medication. PSW #101 further stated that when entering the room to assist with the medication administration, resident #002 was not displaying any signs of needing the medication. PSW #101 said they knew the incident needed to be reported, but that two RPN's (RPN #102 and #103) had witnessed the medication administration and felt they would report the incident to management.

RPN #102 was interviewed and indicated observing RN #100 coming out of the medication room with an inappropriate method for administering the particular medication to resident #002. RPN #102 stopped RN #100 and stated that it was not an appropriate way to administer the specified medication. RPN #102 indicated to the inspector they did not think that resident #002 needed the medication and that RN #100’s actions were inappropriate. RPN #102 indicated that RPN #103 called to report the incident to the on-call manager, Nursing Administrative Services Manger #104.

RPN #103 was interviewed and confirmed calling the on-call manager #104 to report the incident the day it occurred. RPN #103 indicated that resident #002 was heard yelling and when entering resident #002's room they witnessed multiple PSWs holding the resident down and the resident yelling no, no, no. The RPN went in after all of the other staff left and said that the resident was teary and wanted to call the police. RPN #103 indicated reassuring the resident and said they would find out what happened. RPN #103 indicated that a message was left for the on-call manager #104 to call back. The RPN stated that the on-call manager did call back but by this time had already spoken to RN #100 who gave their account of the events that had occurred with resident #002. RPN #103 said they explained that staff were instructed by RN #100 to hold the resident down. RPN #103 further indicated not feeling the specified medication was necessary. RPN #103 typed up their account of the incident dated three days after the incident and placed it in the Director of Care's mailbox.

The Director of Care indicated to the inspector that they did not receive this written statement by RPN #103 until returning to work, approximately 7 days after it was written.

RN #105 worked the evening shift the day the incident occurred and indicated that when coming on shift they assessed resident #002 and found the resident did not require the next dose of the particular medication and told the RPNs to hold the medication. RN #105 also stated that resident #002 indicated not wanting that nurse (RN #100) to come near them ever again and that the resident wanted to call the police and the media. RN #105 stated that resident #002 said that RN #100 put their hands around the resident's

neck. RN #105 said they called and reported to nursing on-call manager #104. RN #105 could not recall the exact words to the on-call manager #104 but knows the reason for the call was because the resident had reported that RN #100 put their hands around resident #002's neck. RN #105 stated they felt the incident needed to be investigated right away.
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The on-call manager, #104, stated in an interview that RPN #103 and RN #105 called the day the incident occurred to discuss the medication that had been given to resident #002. On-call manager #104 indicated to the inspector that no notes were kept from these phone calls. On-call manager #104 stated that RPN #103 reported not being happy with how the medication was given, but gave no other detail. On-call manager #104 said they told the RPN to write it down and submit to the Director of Care. On-call manager stated that RN #105 talked about the resident being upset about getting the medication, but not how they got it. On-call manager #104 said that RN #105 did not indicate during the call on December 23, 2017 that resident #002 was alleging RN #100 had put their hands around the resident's neck. On-call manager #104 stated they did not feel abuse had occurred at this time and this is why an investigation did not begin then.

On-call manager #104 indicated that both staff indicated that resident #002 wanted to call the police and so told staff to let the resident do this and to provide assistance as necessary. RPN #103 and RN #105 indicated to the inspector that the resident could have called the police but decided not to.

Ten days after the incident occurred, a Critical Incident Report was completed by the Director of Care and submitted to the Director (Ministry of Health and Long-Term Care).

The staff to resident alleged abuse that occurred on a specified date was not reported immediately to the Director as required. [s. 24. (1)]

Issued on this 20th day of March, 2018

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

Original report signed by the inspector.