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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2019	2019_520622_0021	006767-19, 013610-19	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

HEATH HEFFERNAN (622)

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): September 3, 4, 5, 6, 9, 10, 2019

The following logs were completed during this inspection:

Log #013610-19/Critical Incident System report (CIS) #2671-000021-19 related to an incident that caused injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

Log #006767-19/CIS #2671-000012-19 - related to a missing/unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Pharmacist/Consultant, the Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the RAI Coordinator/RPN, Personal Support Workers (PSWs), and the residents.

Also during the course of the inspection, the inspector reviewed the critical incident system reports (CIS), the licensee’s investigation documentation, electronic and hard copy health records, Policy # 5-4 related to drug destruction and disposal, Policy # 6-6 related to shift change monitored drug count and registered and non-registered staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
3 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any medication management system policy, the licensee is required to ensure that the policy is complied with.

According to O. Reg. 79/10, s. 114 (1)., every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (2). states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

On September 9, 2019, inspector #622 reviewed Medical Pharmacies - Policy # 6-6 dated revised January 2018, titled - Shift Change Monitored Drug Count which was submitted to inspector #622 by RAI Coordinator #103 who stated that the home uses Medical Pharmacies policies. Policy # 6-6 stated that monitored medications must always be counted on an ongoing basis at designated shift changes in the home to deter the opportunity for drug diversion. The count is to be completed by two registered staff, the one leaving the home with the new one arriving. The two registered staff are to count together the actual quantity of medications remaining, record the date, time, quantity of medication and sign in the appropriate spaces on the shift change monitored medication count form.

On September 9, 2019, inspector #622 reviewed the shift change monitored medication count sheets for residents #003, #006 and #007’s specified monitored medications for

two specified months which indicated that on five specified dates, registered staff signatures were not recorded.

During separate interviews with inspector #622 on September 09, 2019, RPN #110 and RPN #111 stated that monitored medications are counted at the end of each shift between the registered staff leaving and the registered staff coming on shift. There are always two registered staff present during the count and the two registered staff signatures are required on the shift change monitored medication count sheets. Both RPN #110 and RPN #111 stated that they were not aware of any time that a registered staff member performed the monitored medication count alone. RPN #110 and RPN #111 further stated that if there were missed signatures on the shift change monitored medication count sheets, the staff members would have forgotten to sign at the time of the count.

During separate interviews with inspector #622 on September 10, 2019, the Administrator and the Director of Care (DOC) #100 stated that there should have been two registered staff signatures recorded on the shift change monitored medication count sheets related to the monitored medication counts for resident #003, #006 and#007. [s. 8. (1) (b)]

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 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, 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 resident #001 fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

CIS #2671-000021-19 stated on a specified date and time, resident #001 fell and sustained an injury which required a transfer to the hospital.

On September 4, 2019, inspector #622 reviewed the assessment tab on the electronic documentation (Mede-Care), which indicated that a post fall assessment had not been documented for the fall with injury that resident #001 sustained on the specified date.

During separate interviews with inspector #622 on September 5, 2019, the Director of Care (DOC) #100 stated that for each fall, a post fall assessment should be completed under the assessment tab on Mede-Care. The RAI Coordinator #103 reviewed resident #001's assessments tab on Mede-Care and stated that a post fall assessment was not completed for the fall with injury that resident #001 sustained on the specified date. [s. 49. (2)]

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to falls.

On September 4, 2019, inspector 622 reviewed the most recent care plan on the electronic documentation (Mede-Care), which stated that resident #001 was to be part of the "Catch A Falling Star Pictogram-Fall Prevention initiative".

During an observation of resident #001 and their room on September 4, 2019, inspector #622 observed that there were no catch a falling star logos for resident #001 in their room or on their wheelchair.
On September 5, 2019 inspector #622 and RAI Coordinator #103 together, observed that the catch a falling star logo continued to be absent from resident #001’s room and wheelchair.

During separate interviews with inspector #622 on September 5, 2019, the RAI Coordinator #103 and the Director of Care (DOC) #100 stated that the catch a falling star initiative captures residents who have frequent falls. RAI Coordinator #103 stated that the catch a falling star logo is placed at the resident's bed or on their wheelchair. Both the RAI Coordinator #103 and the DOC #100 stated that according to resident #001’s care plan, they should have had a catch a falling star logo in their room and/or on their wheelchair. [s. 6. (7)]

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.