Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 14, 2020	2020_583117_0001	023634-19	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

LYNE DUCHESNE (117), LISA CUMMINGS (756)

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): January 7, 8 and 9, 2020

An inspection was conducted related to Log # 023634-19 in regards to a critical incident report (CIS # 2671-000032-19) regarding an alleged incident of staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs) as well as to several residents.

During the course of the inspection, the inspector reviewed several residents health care records, observed the provision of care including medication administration, observed staff to resident interactions, reviewed agency staff orientation documents, reviewed licensee investigation notes and reviewed the licensee policy # AM-6.9 "Zero Tolerance of Abuse" , policy #AM-6.7 "Reporting Incidents of Abuse" and Resident Bill of Rights.

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

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

- **1 WN(s)**
- **1 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 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 provided to the resident as specified in the plan.

Resident #001 has dementia and presents with periods of verbal and physical aggression. The resident's plan of care indicates that should the resident becomes verbally or physically aggressive during the provision of care, staff are to leave the resident and re-approach later when the resident is calm.

On a specified day in 2019, agency RPN #111 went to the resident #001's room to administer the resident's medication. Resident #001 refused to take the medication and became verbally and physically aggressive towards RPN #111. PSW #109 heard resident #001 yelling and entered the resident's room. The resident was yelling and attempting to hit the RPN. RPN #111 was seen holding one of the resident's hands while attempting to retrieve the medication held in the resident's other hand. PSW #109 verbally redirected the resident and the RPN stepped away from the resident. The resident then threw the medication at the RPN. The RPN left the room and PSW #109 stayed to calm the resident. PSW #109 noted that the resident had a small injury. PSW #109 immediately went to RN #103 and informed them of the resident's behaviours and injury. RN #103 went to resident #001, assessed and treated the injury.

The Administrator, Director of Care and Clinical Care Coordinator indicated that the agency RPN #111 had been working on a casual basis at the home for the past several months and had access to the resident's plan of care. As per RN #103, PSW #109, as well as the home's Administrator, Director of Care and Clinical Care Coordinator, the resident's plan of care identifies that staff are to leave the resident alone when they became aggressive and return later to provide care, this includes medication administration.

As such, RPN #111 did not provide care to the resident as specified in the plan of care when they did not leave and later re-approach the resident when resident #001 became verbally and physically aggressive during medication administration.
[s. 6. (7)]

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 the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of January, 2020

[redacted]

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

Original report signed by the inspector.