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_548756_0001	021711-19	Complaint

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

LISA CUMMINGS (756), LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 7, 8, 9, 2020

Log # 021711-19, related to resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Personal Support Workers (PSWs), and the resident.

Also during the course of the inspection, the inspector reviewed the complaint intake, paper copy and electronic health care records, staff schedules, and made observations of the provision of care to residents.

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

During the course of this inspection, Non-Compliances were issued.
2 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	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care as specified in the plan of care was documented for resident #001 on specified days in November 2019.

On January 9, 2020, a review of resident #001’s ‘Observation / Flow Sheet Monitoring Form’ was conducted for November 2019. On a specified day in November 2019, no documentation was completed for the provision of personal care. On a separate day in November 2019, it was documented that resident #001 refused certain personal care activities. A review of resident #001’s progress notes were completed for these two days in November 2019. No progress notes were found for either day regarding provision or refusal of personal care for resident #001.

During an interview on January 9, 2020, DOC #105 stated the expectation is that staff document all personal care provisions and refusals. In addition, DOC #105 confirmed that when a resident refuses care, the nurse is to be informed and the care refusal documented. [s. 6. (9) 1.]

WN #2: 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 resident #001 received individualized personal care, including hygiene care and grooming, on a daily basis.

A complaint was submitted to the Director which stated that on specified days in November 2019, resident #001 and their wheelchair were found soiled and that personal care was not provided.

The staffing schedule for the specified days in November 2019, indicated that PSW #107 and PSW #108 were assigned to provide care to resident #001.

During separate interviews, PSW #107 and PSW #108 stated that resident #001 did not always receive daily personal care during their shift due to responsive behaviours. PSW #107 stated that there was a day that PSW #108 did not provide personal care to resident #001 for a full shift. PSW #108 confirmed that they did not provide care to resident #001 for a full shift in November 2019. PSW #108 stated that at that time they were unaware of the interventions in place to manage resident #001's responsive behaviours and due to this, resident #001 did not receive personal care on that day.

When interviewed, DOC #105 confirmed that resident #001 should have been provided personal care by PSW #107 and PSW #108 during their shift on the specified days in November 2019. [s. 32.]

Issued on this 15th day of January, 2020

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

Original report signed by the inspector.