Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 29, Aug 1, 2, 3, 4, 5, 8, 9, 11, 12, 15, 2011	2011_048175_0009	Complaint

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nurses, Registered Practical Nurses,residents

During the course of the inspection, the inspector(s) reviewed the home's Policies, Procedures and Program Information including Reporting Incidents of Abuse-Operational Procedures, Critical Incident Reporting, Operations and Nursing, Principles of Respect Always Program, Training and Orientation, Workplace Violence/Respect Always Introduction, Memo dated July 20, 2011, Resident Health Records, Resident Information Package, Contingency Plans for Shortages of Staff on Days and Evenings, Scheduled Staffing schedules from April 25, 2011 to August5, 2011.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits sayants :

1. A resident was admitted to the home with dementia. His wife was admitted to the home and later died. Since the death of his wife, the resident is described by staff as being physically and sexually aggressive with other residents and staff.

2.There were a total of 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents, some random, others targeted and repeated, between December 2010, and July 2011.

3.The licensee failed to protect female residents from the ongoing, sexually aggressive behaviours of the resident towards them. Care interventions implemented to date, have not been effective. The plan of care for the resident has not been modified to the extent that female residents living in the home are protected from his ongoing sexually aggressive behaviours directed at them.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits sayants :

1. A resident was admitted to the home with dementia. His wife was admitted to the home and later, died.. Since the death of his wife, the resident is identified as being physically and sexually aggressive with residents and staff.

2.There are 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents- some random, targeted or repeated from December 2010, to July 2011.

3.Director of Care reported that the Supportive Measures Registered Nurse, conducted a review of residents' plans of care, but no investigations were completed for the fifteen recorded incidents of sexually aggressive incidents.

4.The home's Operational Procedure "Reporting Incidents of Abuse" indicates "the purpose- to ensure all matters required to be reported to the Ministry of Health are investigated and reported within the designated time frames and the procedure indicates a thorough investigation of the incident shall be conducted in accordance with the Investigation Procedures Policy."

5.The home's Director of Care stated on August 3, 2011, that "she was told, and I don't know by whom, If there is an incident of sexual abuse of one resident to another, and there is no harm done, it is not reportable to the Ministry, no Critical Incident Report is necessary."

6.The licensee did not ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone, (ii)Neglect of a resident by the licensee or staff, or (iii)Anything else provided for in the regulations.

WN #3: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits sayants :

1. A resident was admitted to the home with dementia. His wife was admitted to the home and later, died. Since the death of his wife, the resident is identified as being physically and sexually aggressive with residents and staff.

2.There are 15 documented, witnessed, incidents of sexual aggression by the resident towards female residents- some random, targeted or repeated from December 12, 2010, to July 27, 2011.

3.The home's Director of Care stated on August 3, 2011, that "she was told, and I don't know by whom, If there is an incident of sexual abuse of one resident to another, and there is no harm done, it is not reportable to the Ministry, no Critical Incident Report is necessary."

4.No Critical Incident Reports of resident to resident sexual abuse were submitted to the Ministry of Health and Long Term Care for 15 witnessed incidents of sexually aggressive behaviour by the resident
towards female residents, from Dec 2010, to July 2011.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

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Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits sayants :

1. A resident was admitted to the home with dementia. His wife was admitted to the home and later died. Since the death of his wife, the resident is identified by staff, as being physically and sexually aggressive with residents and staff.

2.There are 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents- some random, targeted or repeated, from December 2010, to July 2011.

3.The Director of Care verified that none of the resident families were notified of any of the incidents of resident to resident sexual abuse, with the exception of one incident. The Director of Care reported the reason why this incident was reported to the Ontario Provincial Police (OPP) and the family, is" because one resident was observed laying on top of the other resident."

4.The licensee did not ensure that for fourteen incidents of sexual abuse, the resident's substitute decision- maker, if any, and any other person specified by the resident, was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well being.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits sayants :

1. The home's Zero Tolerance Policy on Abuse and Neglect, referred to in the "Resident Information Package" pg. 4, states that the home will:
uphold the right of each resident to live free from abuse and neglect and to be treated with dignity and respect;

investigate every allegation of abuse in accordance with the complaint investigation policy;

notify the police of any alleged, suspected or witnessed incident of abuse or neglect as required,

report each suspected or confirmed incident of abuse or neglect to the Ministry of Health and Long Term Care (MOHLTC)...

2.A resident was admitted to the home with dementia. His wife was admitted to the home and later, died. Since the death of his wife, the resident is identified as being physically and sexually aggressive with residents and staff.

3.There are 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents- some random, targeted or repeated, from December 2010, to July 2011.

4.The home failed to protect female residents from the ongoing, sexually aggressive behaviours of the resident towards them.

5.The home's Director of Care stated on August 3, 2011, that "she was told, and I don't know by whom, If there is an incident of sexual abuse of one resident to another, and there is no harm done, it is not reportable to the Ministry, no Critical Incident Report is necessary."

6.No Critical Incident Reports of resident to resident sexual abuse were submitted to MOHLTC for 15 witnessed incidents of sexual aggressive behaviour by the resident, some random, targeted or repeated from December 2010, to July 2011.

7.Police were notified of one out of fifteen incidents of sexual abuse.

8. The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents is complied with.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits sayants :

1. A resident was admitted to the home with dementia. His wife was admitted to the home and later, died. Since the death of his wife, the resident is identified as being physically and sexually aggressive with residents and staff.

2.There are 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents- some random, targeted or repeated, from December 2010, to July 2011.

3.The Director of Care verified that none of the resident families were notified of any of the incidents of resident to resident sexual abuse, with the exception of one incident. The Director of Care reported the reason why this incident was reported to the OPP and the family, is "because one resident was observed laying on top of the other resident."

4.Fourteen of the fifteen incidents were not reported to the police.

Issued on this 18th day of August, 2011

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

B Thompson

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BRENDA THOMPSON (175)
Inspection No. / No de l'inspection :	2011_048175_0009
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jul 29, Aug 2, 3, 4, 5 & 9, 11, 12, 15, 2011
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	ROSEBRIDGE MANOR 131 Roses Bridge Road, R. R. #2, Jasper, ON, K0G-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DOROTHY BROEDERS - MORIN

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents in the home are protected from sexually aggressive behaviours directed at them by a resident identified as the aggressor.

The licensee shall ensure that necessary modifications are made to the plan of care of the resident identified as the aggressor to ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. A resident , was admitted to the home with dementia. His wife was admitted to the home and later, died.. Since the death of his wife, the resident is identified by staff as being physically and sexually aggressive with other residents and staff.

2. There are a total of 15 documented, witnessed, incidents of sexual aggression by the resident toward female residents- some random, others targeted and repeated, between December 2010, to July 2011.

3.The licensee failed to protect female residents from the ongoing, sexually aggressive behaviours of the resident t directed towards them. (175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 17, 2011

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 18th day of August, 2011

Signature of Inspector / Signature de l'inspecteur : B. Thompson

Name of Inspector / Nom de l'inspecteur : BRENDA THOMPSON

Service Area Office / Bureau régional de services : Ottawa Service Area Office