Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Care Inspection Branch

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Original Public Report

Report Issue Date: December 20, 2022	
Inspection Number: 2022-1177-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Rosebridge Manor, Jasper	
Lead Inspector Manon Nighbor (755)	**Inspector Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2022.12.20 09:28:21 -05'00'
Additional Inspector(s) Michelle Edwards (655)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 17, 18, 23, 24, 25, 28 and 29, 2022

The following intake(s) were inspected:

- Intake: #00013911-Intake generated for PCI.

The following **Inspection Protocols** were used during this inspection:

Quality Improvement
Infection Prevention and Control
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Resident Care and Support Services
Skin and Wound Prevention and Management
Falls Prevention and Management

Safe and Secure Home
Pain Management
Prevention of Abuse and Neglect
Residents' Rights and Choices
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 166 (2) 8.

The licensee has failed to ensure that the continuous quality improvement initiative for a home required under section 42 of the Act, shall be composed of at least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

Rational and Summary
The Quality Improvement Lead confirmed that the Quality Improvement Committee did not include a staff member of the home who is a personal support worker or someone who provides personal support services (PSW).
The next week, the Director of Care (DOC) indicated that, the committee included a PSW and the PSW confirmed their new membership to the committee.

Sources: Rosebridge Manor-Resident Experience Survey 2022-CQI Action Plan and interview with Quality Improvement Lead, DOC and staff member. [755]

Date Remedy Implemented: November 29, 2022

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure for the purposes of clause 85 (3) (s) of the Act where the required information for the purposes of subsections (1) and (2) is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations which includes the current version of the visitor policy made under section 267.

Rational and Summary
The visitor policy was not posted in a conspicuous and easily accessible location in the home. The Administrator confirmed that the home had a current visitor policy. The visitor policy was posted in the main common area, amongst other required posted policies, the next day.

Sources: Visitor Policy and interview with Administrator. [755]

Date Remedy Implemented: November 18, 2022

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

Rational and Summary
Three resident's plan of care indicated that they required extensive assistance to total dependence for their personal care needs. For one month all three residents' personal hygiene,

toileting and dressing care was provided however the care set out was not documented in point of care on several day and evening shifts.

The Director of Care confirmed that the care provided to the three residents had not been documented.

The lack of documentation caused a minimal risk of harm since the care set out had been provided to the three residents.

Sources: Plan of Care, Point of Care and interview with the Director of Care
[755]