

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

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
Jul 8, 2019	2019_730593_0019	009317-18, 009612- 18, 011197-18, 024987-18, 030637-18	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

Springdale Country Manor
2698 Clifford Line, R.R. #5 PETERBOROUGH ON K9J 6X6

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

GILLIAN CHAMBERLIN (593), JOELLE TAILLEFER (211)

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): June 10 - 14, 2019.

Five intakes were inspected during the inspection:

Log's #009317-18 (CIS 2413-000006-18) and #011197-18 (CIS 2413-000009-18) related to reported medication incidents.

Log's #009612-18 (CIS 2413-000008-18) and #030637-18 (CIS 2413-000020-18) related to alleged resident to resident abuse.

Log #024987-18 related to alleged resident to resident physical abuse and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Nursing Administration Services Manager, Food Service Manager, registered physiotherapist, registered nursing staff, personal support workers, dietary staff, residents and family members.

The inspector(s) observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff schedules and licensee policies.

The following Inspection Protocols were used during this inspection:

Medication

Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A critical incident report (CIS) was submitted to the Ministry of Health and Long Term Care related to a controlled substance missing for resident #001. A second CIS was submitted related to another identical controlled substance missing for the same resident.

In an interview with the DOC on June 13, 2019, stated that a Medication Advisory Committee (M.A.C) team's meeting occurred quarterly to discuss and evaluate the effectiveness of the medication management system and to recommend any changes necessary to improve the system. The DOC confirmed that an annual M.A.C team meeting was not performed nor established to review the quarterly evaluation of the medication management system for the previous year. (Log #009317-18, #011197-18) [s. 116. (1)]

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 ensuring that every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, The Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, being 21 days.

A critical incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged abuse of a resident by resident #006. It was reported in the CIS that RN #101 was exiting the medication room when they saw resident #006 talking to another resident who was standing and leaning over resident #006. Resident #006 had his hands on a specific area of the body.

The CIS initially submitted did not include the analysis and follow up including the immediate actions to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence. The CIS was amended with this information, 58 days after the CIS was initially submitted (log #030637-18). [s. 104. (3)]

Issued on this 10th day of July, 2019

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

Original report signed by the inspector.