Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2013	2013_195166_0040	O-001005-13	Critical Incident System

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE, R. R. #5, PETERBOROUGH, ON, K9J-6X6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 28, 2013

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Physician, Administrator, Registered staff and Personal Support staff.

During the course of the inspection, the inspector(s) reviewed the clinical health records of two identified residents and the licensee's policies , AM-6.7 Reporting Incidents of Abuse, AM-6.9 Zero Tolerance of Abuse and Neglect of Residents, AM-6.3 Investigation Procedures and Abuse of Residents by Residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs of that resident.
On identified date, an allegation of resident to resident sexual abuse was reported.
Review of clinical documentation did not provide any evidence of an assessment of Resident #1 post incident.
Interview with RN #110 confirmed that Resident #1 was not assessed post incident.
[s. 6. (2)]

2. The licensee failed to ensure that staff and others who provide direct care to residents have convenient and immediate access to residents' plans of care.
RPN #100 (Registered Practical Nurse) indicated residents' plans of care are kept electronically and require a password for access .
Six PSWs (Personal Support Workers) interviewed indicated they had recently been given a password to the computer but were unsure how to access the residents' plans of care. [s. 6. (8)]

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 the licensee shall ensure that care set out in the plan of care for the resident is based on an assessment and the needs of the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to notify Resident #1's substitute decision maker immediately of an alleged incident of abuse.
Review of the licensee's policy" Reporting Incident of Abuse" Policy # AM-6.7 states;
-A resident's family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect immediately after it is reported...
Interview with RN #100, RN #110 and the Administrator and review of Resident #1's clinical record indicate the Resident's substitute decision maker was not notified immediately after the alleged incident occurred. [s. 97. (1) (a)]

Issued on this 7th day of November, 2013

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