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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 27, 2016	2016_291194_0029	000197-16, 015058-16, 019803-16, 020741-16, 030235-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

PLEASANT MEADOW MANOR
99 Alma Street P. O. Box 426 Norwood ON K0L 2V0

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

CHANTAL LAFRENIERE (194)

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): October 24 and 25, 2016

The inspector completed the following Critical Incident Inspections; Logs #020741-16, #015058-16 related to allegations of staff to resident physical abuse, Logs #019803-16, #030825-16 related to missing narcotics and Log #000197-16 related to misappropriation of residents money.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator/Director of Care(DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Life Enrichment Coordinator (LEC), Life Enrichment Aide (LEA) and Office Manager.

The inspector also review clinical health records of identified residents, medication and abuse policies, staff educational records, licensee's internal investigation and identified residents administration files. The inspector also observed staff to resident interaction during the provision of care

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

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On an identified date, the family member of resident #001 notified RN #100 of an allegation of staff to resident physical abuse involving resident #001. The family member reported to RN#100 that resident #001 had alleged the night staff had been physically abusive. RN #100 notified the on call manager RPN #104 of the allegations received. RPN# 104 initiated the Critical Incident Report (CIR) and believed that the Director had been notified by this action, but did not submit the CIR until the following day.

During an interview RPN #104 indicated to inspector #194 that she believed the Director had been notified by initiating the CIR. RPN #104 indicated that the Director had not been immediately notified of the allegations of staff to resident physical abuse on the identified date. [s. 24. (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 by ensuring that the person who has reasonable ground to suspect that any of the following has occurred or may occur, immediately reports the suspicions and the information upon which it is based to the Director.
(2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that result in harm or risk of harm, to be implemented voluntarily.

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:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the allegation of staff to resident physical abuse investigation involving resident #001 were reported to the Director

On an identified date, the family member of resident #001 notified RN #100 of an allegation of staff to resident physical abuse involving resident #001. The family member reported to RN#100 that resident #001 had alleged the night staff had been physically abusive. The licensee's investigation resulted in no evidence to support the allegations of staff to resident physical abuse had occurred.

During an interview the Administrator/ DOC indicated to inspector #194 that the results of the allegations of staff to resident physical abuse investigation involving resident #001 on the identified date had not been reported to the Director. [s. 23. (2)]

Issued on this 31st day of October, 2016

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

Original report signed by the inspector.