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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2017	2017_664602_0026	019234-17	Resident Quality Inspection

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

ROSEBRIDGE MANOR
131 Roses Bridge Road R. R. #2 Jasper ON K0G 1G0

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

WENDY BROWN (602), ANANDRAJ NATARAJAN (573), HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 4- 8 and September 11 & 12, 2017

The following inspections were completed concurrently with the Resident Quality Inspection:
Log #002454-17 – Critical Incident concerning a fall with injury
Log #013857-17- Critical incident concerning a medication error with transfer to hospital

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Care Coordinator, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Nutrition Care Manager, the Environmental Services Manager, Housekeeping staff, the Restorative Care Coordinator, family members, volunteers and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in a resident's plan of care is provided to the resident as specified in the plan.

A resident was admitted to the home on a specified date. The resident's assessment on a specified date indicated that the resident required a specific type of regular care. The resident's written plan of care was reviewed and indicated that the resident was to receive this care at specific times.

During separate interviews with Inspector #573, three PSWs indicated that the resident did not receive the care as directed in the written plan of care at the scheduled times. An RN was interviewed and indicated that the resident was on a specific care plan and that PSW staff are to provide this care. The inspector spoke with the home's RAI- Coordinator who also indicated that PSW staff are to provide the scheduled care as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every medication incident involving a resident has been reported to the resident or the resident's substitute decision-maker. O. Reg. 79/10, s.135 (1) (b)

Three medication incident reports occurring over a specified period were reviewed. The resident and/or substitute decision maker(s) (SDM) were not notified of the medication incident in two of the three reports.

A review of the home's medication incident report on a specified date indicated a resident missed a dose of a specific medication. The incident report indicated that the resident was assessed post incident with no residual effects. The Director of Care (DOC) and the Administrator reviewed the incident and followed up with the staff involved. No documentation was noted indicating the resident or SDM had been notified of the incident.

A review of the home's medication incident report on another specified date indicated a different resident missed a dose of a specific medication. The incident was filed on the home's medication incident report and indicated the resident was assessed post incident with no residual effects. The DOC and the Administrator reviewed the incident and followed up with the staff involved.

No documentation was noted in either residents' reports indicating the resident or the SDM had been notified of the incident. There was no documentation in either residents' progress notes noting that the resident or the SDM were informed of the medication incidents.

During separate interviews on a specified date, two RPNs indicated all medication incidents are to be reported to either the resident or the SDM and/or power of attorney (POA). The RPNs indicated the medication incident for one of the residents should have been reported to the resident as s/he does not have a POA and s/he would remember being informed of the medication incident. Furthermore the RPNs indicated the medication incident for the other resident should have been reported to the resident's SDM. The DOC indicated that residents and/or their SDMs had not been notified of the medication incidents as the home only notifies residents /SDMs of medication incidents with adverse reactions. After discussion with inspector #622 and a review of the legislation, the DOC indicated the resident(s)/SDM(s) should have been notified of the medication incident(s). [s. 135. (1)]

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

---

Issued on this 20th day of September, 2017

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

Original report signed by the inspector.