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 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2019	2019_520622_0001 (A1)	028068-17, 010863-18, 028663-18, 030691-18	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

Rosebridge Manor
131 Roses Bridge Road, R.R. #2 Jasper ON K0G 1G0

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

Amended by HEATH HEFFERNAN (622) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

The Licensee report has been amended to ensure consistency.

Issued on this 20th day of February, 2019 (A1)

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

Original report signed by the inspector.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by HEATH HEFFERNAN (622) - (A1)

Amended 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): February 11, 12, 13, 14, 2019

The following intakes were included in this inspection:

Log #028068-17 Critical Incident System report (CIS) #2671-000012-17 - related to an incident which caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Log #010863-18/ CIS #2671-000016-18 - related to alleged staff to resident sexual abuse.

Log #028663-18/ CIS #2671-000021-18 and log #030691-18/ CIS #2671-000025-18 related to alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Care Coordinator (CCC), the NASM, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aids (HCA), and the residents.

During the course of the inspection, the inspector reviewed the applicable critical incident intakes, the licensee's investigation documentation, health records, the Licensee's policies and procedures related to Zero Tolerance of Abuse and Neglect of Residents, Investigation, Falls Prevention, observed resident care and services and staff to resident interaction.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **1 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	Légende 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 :

The Licensee has failed to ensure that 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: Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

Critical Incident System report (CIS) #2671-000021-18 indicated that an incident of resident to resident physical abuse of resident #005 by resident #003 occurred on a specified date and time. The CIS report indicated that the Ministry of Health and Long Term-Care (MOHLTC) after-hours pager was not called. The CIS report was submitted to the MOHLTC one day after the incident occurred.

During an interview with inspector #622 on February 14, 2019 at 1430 hours, the Administrator indicated that legislation would state that incidents of alleged, suspected or witnessed abuse were to be reported immediately. The Administrator also stated that the Ministry of Health and Long-Term Care (MOHLTC) after-hours pager had not been called to report the incident of resident to resident abuse between resident #003 and resident #005 on the specified date. Inspector #622 indicated to the Administrator that the CIS report was submitted to the MOHLTC one day after the incident of resident to resident physical abuse occurred. The Administrator stated that the incident had not been reported immediately. [s. 24. (1)]

Issued on this 20th day of February, 2019 (A1)

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

Original report signed by the inspector.