Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Ottawa District**
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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|---|
| **Report Issue Date:** June 1, 2023 |
| **Inspection Number:** 2023-1319-0002 |
| **Inspection Type:**<br>Complaint<br>Critical Incident System |
| **Licensee:** 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership |
| **Long Term Care Home and City:** Forest Hill, Kanata |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Gurpreet Gill (705004) | Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.06.02 13:52:50 -04'00' |

**Additional Inspector(s)**
Marko Punzalan (742406)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 4-5, 8-12, and 15-19, 2023.

The following intake(s) were inspected:

- Intake: #00022299 and Intake: #00022910- complaint related to care and services to residents, documentation, availabilities of supplies, medication administration, alleged staff to resident abuse, skin and wound, recreation activities, laundry and housekeeping services, maintenance issues, infection prevention and control, hot and cold temperature, insufficient staffing and mechanical lift transfers/training and education
- Intake: #00083960 and Intake: #00084814- complainant related to care concerns of a resident and mechanical lift and transfer and training
- Intake: #00014193 - CI:2834-000018-22- related to alleged financial abuse
- Intake: #00014649 - CI:2834-000020-22-related to the operation of the call bell system
- Intake: #00085190 - CI:2834-000006-23- related to a fall incident that caused injury to a resident and a significant change in condition

- The following intakes were completed in the Critical Incident System Inspection: Intake: #00017861, CI: 2834-000003-23 and Intake: #00085860, CI: 2834-000008-23 were related to fall incidents that caused injury to residents and resulted in a significant change in condition

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Recreational and Social Activities
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for three residents.

**Rationale and Summary**

The residents were scheduled to receive a bath or shower twice weekly, as per their plan of care.

The point of care (POC) documentation for a resident showed that for the month of April 2023 until mid-May 2023, there was one day each month where the resident's baths were documented as the "activity did not occur".

The point of care (POC) documentation for another resident showed that for the month of April 2023, there were two days indicating that the "activity did not occur" and one day of missing documentation, and for the month of May 2023 there was one day where the resident bath was documented as the "activity did not occur".

The point of care (POC) documentation for another resident showed that for the month of April 2023 until mid-May 2023, there were two days in each month where the resident bath was documented as the "activity did not occur".

During an interview, the Director of Care (DOC) and the Assistant Director of Care (ADOC) indicated that residents received their scheduled biweekly baths, but the staff either documented it incorrectly or did not complete their documentation in the POC.

**Sources**: Residents' health care records and interviews with the DOC and the ADOC. [705004]

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