



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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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**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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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
Oct 6, 2014	2014_200148_0031	O-000880- 14	Complaint

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

GARDEN TERRACE
100 Aird Place, KANATA, ON, K2L-4H8

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 17 and 18, 2014.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC) and identified resident.

During the course of the inspection, the inspector(s) reviewed the identified resident health care record and the home's discharge information related to the identified resident.

**The following Inspection Protocols were used during this inspection:
Admission and Discharge**



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10, s.144, whereby no licensee shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation.



O.Reg 79/10, s.145, s.146 and s.147, describe when a licensee is permitted or required to discharge a resident in a long stay bed. Applicable to this inspection, section 145(1) of Regulations 79/10, describes that a resident may be discharged if care requirements have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. Additionally, section 146(4)(a) of Regulations 79/10, describes that a long stay resident may be discharged if on a medical leave of absence that exceeds 30 days.

Resident #1 was admitted to the home on a specified date. The Resident, who is capable of making care decisions, required increased care needs due to diagnosis, skin wounds and increased body weight. The resident had been in and out of hospital for the purposes of assessment on several occasions during his/her stay at the home. On a specified date, Resident #1 was sent to hospital for care needs related to skin wounds on his/her lower legs, with the expectation he/she would be returning to the home. The Administrator and DOC kept in contact with the resident and hospital during the resident's absence, inquiring about the resident's care needs and discharge plans. With information that the resident would not be returning within the 30 day medical leave the home agreed to have the resident return for a one night stay. On a specified date, Resident #1 was admitted to the home and on the following day, Resident #1 was discharged back to hospital.

The Administrator and DOC kept in contact with the resident and hospital during the resident's subsequent absence, inquiring about the resident's care needs and discharge plans. During this period, the DOC was informed the resident would require two more weeks in hospital. With information that the resident would not be returning within the 30 day medical leave the home agreed to have the resident return for a one night stay. On a specified date, Resident #1 was admitted to the home and on the following day, Resident #1 was discharged back to hospital.

On a specified date, the home's Administrator spoke with Resident #1, at which time the resident reported that he/she was going to need extensive rehabilitation. The 30 day medical leave was discussed and the resident requested the home bring him/her back as necessary to ensure he/she would not exceed the 30 day medical leave of absence.

On a specified date, after discussion with members of the medical team, Community Care Assess Center and the licensee, a decision was made to discharge Resident #1.



Resident #1 was informed of the discharge, on the same date, by phone call from the Administrator and by letter.

A letter to Resident #1 indicates the following grounds for the discharge:

- "...continued need and request for extended leave of absence are further evidence that your complex care needs exceed the nursing care and expertise that the home is able to provide."
- "...the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident..." (The letter citing O.Reg s.145(1))

The letter and grounds for discharge were discussed with the home's Administrator and DOC. Both managers indicated a concern with recurrent use of the 30 day medical leave, the resident's increase care needs, and the resident's increased need for assistance with activities of daily living. Section 145 of Regulation 79/10 was discussed and it was determined that the resident care requirements have not changed in a way that would indicate the resident requires a secure environment for the safety of the resident or others.

On August 8, 2014 Resident #1 was discharged from the home, the grounds for the discharge is not permitted under Regulation 79/10.

Issued on this 6th day of October, 2014

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