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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Aug 5, 2015	2015_450138_0003	O-001895-15, O-001794-15, O-001862-15	Critical Incident System

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

PAULA MACDONALD (138)

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): July 16, 17, 28 and August 4, 2015.

Log O-002522-15 was initiated and completed during the course of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, a Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), and a resident.

While in the home, the inspector reviewed several Critical Incident Reports, reviewed several policies and procedures, reviewed several resident health care records, reviewed the home's internal investigation documents, and reviewed partial employee records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 failed to comply with section 6.(7) of the Act in that the licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

1) The home submitted a Critical Incident Report to the Director on March 19, 2015, outlining that Resident #002 had not been provided timely assistance with toileting as requested by the resident on an evening in March 2015.

The inspector reviewed the home's internal investigation files, including signed statements from staff involved in the incident, and noted that the resident had rung the call bell shortly after 5:00 pm for assistance with toileting needs. The internal investigation documents show that PSW #103 responded to the call bell but did not provide assistance with toileting at that time. Later that evening at 6:30 pm, Resident #002 got the attention of Activity Worker #105, whose signed statement indicated that Resident #002 told her that the resident had been incontinent since 5:00 pm. Activity Worker #105 informed PSW #104 about Resident #002's needs. Staff #104 proceeded to the resident's washroom and at 6:37 pm rang the resident's call bell to alert for an additional staff member to assist with the resident.

A signed statement provided by the unit RPN #106, regarding that specific evening, demonstrated that Resident #002 approached the unit nurse at approximately 7:30 pm with concerns that s/he had not been provided assistance with toileting needs for two hours and as result was left sitting in an soiled incontinent product.

On July 16, 2015, the inspector spoke with Resident #002 who stated that the resident cannot toilet self and requires complete assistance from staff to carry out toileting activities. The resident further stated that s/he will ring the call bell when assistance is needed for toileting and staff will normally come fairly quickly to provided the assistance. Resident #002 further stated that on the specific evening in March 2015, staff had not provided the resident with the necessary toileting assistance after ringing the call bell and as a result s/he had been incontinent. The resident stated that s/he was upset at being required to wait almost two hours for toileting assistance.

The inspector reviewed the plan of care, as defined by the home, for Resident #002's toileting needs. The plan of care outlined that the resident will ring the call bell for toileting assistance and that the staff will provide two person assistance. The inspector spoke with several staff members regarding the toileting care for Resident #002, including PSW #104, and all stated that the resident will ring the call bell when assistance is required and staff will then attend to the resident as quickly as possible.

On an evening in March 2015, Resident #002 was not provided toileting care as outlined

in the resident's plan of care.
(O-001862-15)

2) The home also submitted another Critical Incident Report to the Director on July 28, 2015, outlining that Resident #004 had not been provided timely assistance on an evening in July 2015 with continence care resulting in the resident wearing a soiled incontinence product for approximately two and a half hours.

Again, the inspector reviewed the homes internal investigation files, including signed statements of staff involved in the incident, and noted that unit RPN #107 confirmed with PSW #108 at 5:30 pm that Resident #004 was incontinent of stool. RPN #107 noted that Resident #004 was in the same condition some time later at 8:00 pm. PSW #108 declared in a signed statement that she had not provided care to the resident at the time the resident was first noted to be incontinent until approximately 7:45 pm.

The inspector reviewed Resident #004's plan of care and noted that plan of care for toileting directs staff to ensure the resident is clean and dry by toileting the resident every two hours. The home failed to follow the resident's plan of care in that the resident was not toileted every two hours and was not kept clean on a specific evening in July 2015. (O-002522-15) [s. 6. (7)]

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 to ensure residents are toileted according to their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 8. of the Regulation in that the licensee failed to comply with any policy or system where the Act or the Regulation requires the licensee of a long term care home act to follow.

1) In accordance with this section and sections 30.(1) and 49. of the Regulation, the licensee is required to have in place a falls prevention and management program with appropriate policies that the licensee is to comply with.

The inspector reviewed a Critical Incident Report along with home's internal investigation documents related to this incident. It was noted in a signed statement by PSW #102 that Resident #001 had been found on the floor on an evening in February 2015, with the chair that the resident had been seated in tipped to the side. Resident #001 was discovered to have a small skin tear, most likely related to the fall, found later that same evening during evening care. PSW #102 documented that she may not have reported Resident's #001's fall to the unit nurse however did report the skin tear. The inspector reviewed the interview notes and the signed statement from the unit nurse, RPN # 109, and RPN #109 documented that she had not been made aware of Resident #001's fall. Resident #001's health care record was reviewed and it was noted that there was a progress note entered by the RPN #109 later in the evening that outlined the resident's skin tear and behaviours that were exhibited that evening. There had been no mention of a fall as the unit nurse had not been made aware nor was any post fall assessment completed.

The inspector obtained a copy of the home's policy for falls titled Resident Falls, Policy #CS-12.1 with an effective date of January 2013. This policy outlines that the registered staff shall be notified immediately when a fall occurs. PSW #102 received disciplinary

action for failure to report to the nurse Resident #001's fall that occurred on an evening in February 2015.
(O-001794-15)

2) In accordance with this section and section 20. of the Act, the licensee is required to ensure there is a written policy and system in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy and system is complied with.

The inspector reviewed a Critical Incident Report that outlined a potential incident of abuse to Resident #001 by PSW #102 that was witnessed by PSW #101 on an evening in February 2015. After witnessing the incident, PSW #101, left Resident #001 alone with PSW #102 and failed to report the incident for several days until it was reported to RPN #106 sixteen days later. RPN #106 did not report the incident until the following day at approximately 3:25 pm when it was reported to the Administrator.

The inspector reviewed the home's policy, Zero Tolerance of Abuse, and noted that it directs any staff member who may witness/suspects/hears about abuse to first ensure resident safety and then to report the incident to the direct manager, Director of Care or Administrator. On July 17, 2015, the inspector clarified with several RPNs, RPN #110 and RPN #111, as well as the Administrator, the meaning of the direct manager, Director of Care or Administrator outside of normal business hours and all responded that the system in place afterhours is for staff to immediately notify the charge RN who will then inform the appropriate manager or Administrator.

The home's policy and established system related to resident abuse was not complied with regarding this specific incident in that PSW #101 left PSW #102 alone with Resident #001 after witnessing potential abuse and did not ensure Resident #002's safety . In addition, PSW #101 did not immediately report the incident, instead waiting sixteen days to report the incident. RPN #106 also failed to follow the home's policy and system related to resident abuse in that RPN #106 did not immediately report the incident to the charge RN once becoming aware of the incident and instead reported the incident the following day.
(O-001794-15)

The inspector also reviewed another Critical Incident Report that identified a potential incident of neglect/abuse for Resident #004 on an evening in July 2015, in which RPN #107 observed PSW #108 had left the resident in a soiled incontinent product for over two hours. The incident was not immediately reported to the charge RN, as is the

system established in the home during afterhours. The incident was reported by RPN #107 two days later to the Clinical Care Coordinator. The internal investigation documents demonstrate that an internal investigation then commenced and interviews with staff and management of the home began the following day. ~~Despite the internal investigation that was underway once the incident was reported, the home did not follow its abuse policy which states any suspected abuse is required to immediately be reported to the Director. The incident was not reported to the Director until eight days later, when the Administrator discussed the incident with the inspector and submitted the Critical Incident Report.~~ Omit - Not applicable. PNL.
(O-002522-15)

3) In accordance with this section, section 30.(1) of the Regulation, and section 8. of the Act, the licensee is required to have in place appropriate policies and systems for nursing and personal support services and to comply with these policies and systems.

The inspector reviewed Critical Incident Report #2882-000007-15 along with home's internal investigation documents related to this incident and noted that Resident #001 sustained a fall in February 2015 in another resident's room. The home's internal investigation documents demonstrate that PSW #102, along with and PSW #101, used a mechanical lift to take the resident from the floor and, while still in the mechanical lift, transported the resident down the hall to the resident's room.

The inspector obtained a copy of the home's policies, Preparing for Lifts and Transfers and Resident Transfers, both listed under the Nursing classification, and reviewed these policies. These policies outlined a purpose to provide a safe method of transfer and to minimize risk to the resident and staff. The Resident Transfer policy outlined that a transfer is a procedure to assist a resident to move from one surface to another (e.g. bed to chair). The inspector spoke with RPN #112 regarding these policies and RPN #112 stated that transfer with a mechanical lift is only to move the resident from one surface to another such as from a bed to a chair or from a chair to a bathtub and that a mechanical lift should never be used to transport a resident from one room to another as there is a risk of injury. RPN #112 further stated that the home provides training that outlines that mechanical lifts are not to be used to transport residents.

The home provided disciplinary action to PSW #102 for transporting Resident #001 with a mechanical lift from one room to another room.
(O-001794-15) [s. 8. (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 ensure staff are following policies and systems established in the home related to the reporting of resident abuse, to be implemented voluntarily.

Issued on this 5th day of August, 2015

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

Original report signed by the inspector.