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

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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
Jan 10, 2017	2016_548592_0031	018654-16, 019893-16, 021314-16	Critical Incident System

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

MELANIE SARRAZIN (592)

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): December 21, 22, 28, 29 and 30th, 2016

The following critical incidents were inspected concurrently during this inspection:

Log #018654-16 related to an alleged resident to resident physical abuse incident
Log #019893-16 related to resident injury with hospitalization and change in condition and
Log #021314-16 related to an alleged staff to resident physical abuse incident

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Behavioural Support Personal Support Worker (BSO/PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI MDS Coordinator, two Director of Care and the Administrator.

During the course of the inspection, the inspector conducted a tour of the resident care areas, reviewed residents' health care records, licensee's policies and procedures including abuse and neglect and licensee's internal investigation report , staff work routines, observed resident common areas, delivery of resident care and services and the resident to resident interactions and staff to resident interaction.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 ensure the care set out in the plan of care was provided to resident #003 while providing her shower as specified in the plan.

This finding is related to Log #019893-16.

A review of resident #003's health care records indicated that the resident has several medical conditions.

The licensee submitted a critical incident report, involving resident #003 who was diagnosed with a fracture. The critical incident report further indicated that the cause of the fracture was not known, however the resident had a fall in the shower room several days prior to the diagnosis while leaning forward in the shower chair to get his/her hair washed and fell forward onto the floor.

A review of resident #003's current plan of care at the time of the incident was completed by Inspector #592. The plan of care indicated under bathing and shampooing that the resident was totally dependent and that the staff were to provide complete assistance to the resident. The plan of care also indicated that the resident needed to be in a tilting commode chair for his/her showers.

On December 28, 2016, during an interview with resident #003, she indicated to Inspector #592 that he/she had a fall in the shower several days before he/she was diagnosed with the fracture. The resident further indicated that the shower chair was not tilted on that day and that usually the staff members always tilting the shower chair, however he/she did not noticed that the shower chair was not tilted and when PSW #106 went to wash his/her back, he/she fell forward. Resident #003 indicated to the Inspector that he/she fell on his/her knees and hands and that since the incident, two staff members are assisting him/ her with his/her shower and the staff ensures that the shower chair is tilted backwards.

On December 28, 2016, during an interview with PSW #106, she indicated to Inspector #592 that she was working at the home as a PSW student and does recall the incident involving resident #003. PSW #106 indicated that she has asked a PSW on the floor on that day, if there was anything that she should be aware of, before providing the shower to resident #003. She further indicated that the PSW forgot to inform her about tilting the shower chair and that when the resident requested to have his/her back washed, she asked the resident to lean forward and then the resident fell. PSW #106 indicated to Inspector #592 that the information with specific interventions for the shower was in the

resident's plan of care but she did not have the time to look and that she was relying on other staff members on that day.

On December 28, 2016, during an interview with the Administrator, she indicated to the inspector that the home has done a follow-up and that the shower chair was not tilted at the time of the incident and that the instructions were clearly indicated in the resident's plan of care. She further indicated that since the incident, the home had put a memo on the bathing schedule to make sure the resident #003's chair is tilted while in the shower chair as specified in the plan of care. [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 that the care set out in the plan of care for resident #003 is provided to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that it complied with its policy to promote zero tolerance as per the LTCHA, 2007, S.O. 2007, c. 8, s.20(1), when the abuse of a resident was not immediately reported to the Director, as indicated under the LTCHA, 2007, S.O. 2007, c. 8, s. 20(2)(d).

According to O.Reg.79/10, s.2.(1) physical abuse is defined as:

(a) the use of physical force by anyone other than a resident that causes injury or pain;

This finding is related to Log # 021314-16.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding an alleged physical abuse which occurred from a staff member to a resident.

A review of resident #004's health care record was completed by Inspector #592. It was noted that resident #004 had reported to his/her family member that he/she was struck and kicked by a staff member resulting in a skin tear to his/her right wrist. It is further indicated that the family member was on site on that day and had reported the incident to the RPN #109. It is further indicated that the family member was inquiring on what happened to the resident's wrist. The progress notes indicates that RPN #109 told the family member that it was reported to him by a staff member about resident's #004 skin tear but was unsure on how it happened. It is further indicated in the progress notes that the family member told RPN #109 that it is not new for resident #004 to say someone struck him/her and that we could not believe all what he/she says.

The home's policy on Zero Tolerance of Abuse and Neglect of Residents number AM-6.9 (dated on June 2015), indicates that abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to their respective supervisor. Failure to report abuse of any kind is subject to disciplinary action.

On December 29, 2016, in an interview with RPN #109 who was present at the time of the incident, he indicated to Inspector #592 that the family member of resident #004 had reported to him that the resident complained that he/she was struck and kicked by a staff member resulting in a skin tear to his/her right wrist. He further indicated to Inspector #592 that the family member was inquiring on how the resident got the skin tear. RPN #109 further indicated that he did not report the incident because the family member told him that it is was not new for resident #004 to complaint about being struck, therefore he only focused on taking care of the resident's skin tear for that day and did not report the incident to the charge nurse. RPN #109 indicated to Inspector that the home had contacted him two days after the incident and that he was told by his manager that he should of report the incident immediately to the charge nurse and his managers due to the statement from resident #004 and the skin tear outcome regardless of the family statements.

When the licensee became aware of the alleged incident of physical abuse, it was

reported immediately to the Director.

Review of the licensee's internal investigation report was done by Inspector #592. The investigation report indicated that RPN #109 has met with the managers and was told by the Administrator that he should have reported the incident to the charge nurse when he became aware of the incident because it was considered alleged abuse and that it should have been reported to the Police and to the Ministry immediately.

A VPC was issued in November 2016, inspection # 2016_200148_0044 following the date of this critical incident submission. [s. 20. (1)]

Issued on this 26th day of January, 2017

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

Original report signed by the inspector.