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
Mar 30, 2017	2017_617148_0009	020864-16, 022354-16, 025244-16, 026801-16, 027013-16, 027484-16, 027554-16, 030228-16, 003296-17, 004845-17, 005557-17	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

AMANDA NIXON (148)

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): March 15-17, 20-24, 27 and 28, 2017.

This inspection included eleven critical incident reports; eight related to alleged abuse, two related to falls with injury and one related to improper care.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, both Directors of Care, RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), family members and residents.

In addition, the Inspector reviewed resident health care records and documents related to the licensee's investigations, as applicable. The inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions and the residents’ environment.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and other who provided direct care to the resident.

A critical incident report (CIR) was submitted to the Director on a specified date, describing the fall of resident #015. The CIR indicates that while PSW #120 was providing toileting assistance the resident lost balance and fell to the floor. The resident was assessed by registered nursing staff and no injuries were identified. On the following day, due to the resident's pain and difficulty to weight bear, the resident was sent out to hospital where an injury was identified. The CIR indicates that the plan of care required one staff member for toileting.

Inspector #148, reviewed the plan of care in place at the time of the fall, which indicated the resident had a risk of falls to which interventions were implemented. The plan further indicates, under the item of toileting, that the resident required extensive, one person assist for toileting. Within the items of incontinence, it described the resident was on a scheduled toileting program whereby two staff were to provide toileting. In addition, the plan of care indicates the resident required extensive, two person assist for transfers.

The Inspector spoke with two PSWs familiar with the resident’s care prior to the fall. PSW #119 indicated that prior to the fall the resident required one staff person to assist with toileting, but at times may require a second staff person if the resident was agitated or exhibiting aggressions. PSW #118 indicated that prior to the fall the resident required one staff person to assist with toileting; there were no circumstances identified by PSW #118 when two person assist would have been used for toileting.

The Inspector spoke with the home’s RAI Coordinator, who added the scheduled toileting program to the plan of care. The RAI Coorindator confirmed the intention of the addition was to ensure two staff were present for toileting. She noted this was in response to not only the resident’s risk of falls but also the residents behaviours related to resisting care. She indicated that the two person assist with toileting was reflected in the Point of Care information and was accessible to PSW staff members.

The plan of care available at the time of the fall included directions to staff indicating the need for one person and two person assist during toileting. It was determined that the intent of the plan was to provide two person assist, however, staff interviews indicate that this intervention was not clear. Resident #015 was provided toileting with one person

assist and had a fall. [s. 6. (1) (c)]

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 written plan of care for resident #015 sets out clear direction to staff providing care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 was bathed by the method of his or her choice.

On a specified date, the Administrator of the home submitted a critical incident report to the Director, describing that on the same date PSW #113 was overheard by PSWs #112 and #114 to refuse putting water in the tub for resident #012. The resident's plan of care at the time and discussion with the resident's substitute decision maker, indicates that the resident prefers the provision of a bath.

Inspector #148 spoke with resident #012, PSW #113 and PSW #112. It was determined that the resident is able to communicate his/her preferences of bathing at the time bathing is provided. The bathing book used by PSW staff and the resident both indicate the resident prefers to have a bath. PSW #113 indicated that on the specified date, she had placed the resident in the tub, but washed the resident with the shower head as the resident wanted the care to be done quickly. Witness statements collected by the home during their investigation and the Inspectors interview with PSW #112 indicate that the resident was asking for water in the tub and that this was not provided.

On a specified date, resident #012 was not bathed by the method of his/her choice. [s. 33. (1)]

Issued on this 30th day of March, 2017

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

Original report signed by the inspector.