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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 9, 2018 | 2018_708548_0002 | 009733-17, 010299-17, 010649-17, 016262-17, 029103-17 | Critical Incident System |

**Licensee/Titulaire de permis**

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

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**

RUZICA SUBOTIC-HOWELL (548)

## 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): February 8,9,12,13,14,15 and 16, 2018**

**During the course of the inspection the inspector observed resident, staff to resident interaction, reviewed policies related to Fall Prevention, resident health care records and the homes investigative notes.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Clinical Care Coordinator/RAI Coordinator, Registered nurses and Registered practical nurses, Life Enrichment Aide and Charge Nurse**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 that the care set out in the plan of care is provided to resident #003 as specified in the plan.

A critical incident report was submitted to the Director under the LTCHA, 2007 regarding resident #003 having sustained an injury. The resident was found in their room.

Resident #003 requires extensive assistance for daily activities. Fall prevention interventions are communicated in the plan of care and specified specific interventions on how to position the resident while seated in their wheelchair.

On the day of the incident the resident was transported via wheelchair to their room by a staff member. The resident was left unattended in their wheelchair.

RPN #109 indicated to Inspector #548 that on the day of the incident the resident #003 was found on the floor in their room, injured, beside the wheelchair. RPN #109 indicated that the resident had not be positioned as required while seated in the wheelchair. RPN #109 explained that the resident required specific positioning interventions when left unattended to discourage the resident from attempting to stand, on their own. The Administrator indicated that the wheelchair was not positioned as specified, the resident attempted to stand, fell and sustained an injury.

The licensee failed to ensure the wheelchair was in a specified position as identified in the plan of care for resident #003. [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 the plan of care is provided to resident #003, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure resident #003 had been assessed post-fall using a clinically appropriate assessment instrument that is specifically designed for falls.

See WN #001

A critical incident report was submitted to the Director under the LTCHA, 2007 regarding resident #003 having sustained an injury. The resident was found in their room, unattended and required to be transferred to hospital for further interventions.

Resident #003 requires extensive assistance for daily activities. Fall prevention interventions are communicated in the plan of care and specified specific interventions on how to position the resident while seated in their wheelchair.

The home's has a clinically appropriate electronic post-fall assessment tool. The health care record was reviewed.

RN #107, RPN #109 and Clinical Care Coordinator (CCC) #101 all indicated that the home's post-fall assessment tool is to be conducted after all (witnessed or not) fall incidents. The two registered nursing staff members indicated that the post-fall assessment provides information related to the contributing factors related to the fall. The CCC indicated that staff are instructed to complete a post- fall assessment and with scheduled audits the home ensures that the post-assessment is completed. The CCC explained there was a change in staffing at the time of the time of the incident and it had not been included in the audit.

The health care record was reviewed by the CCC and Inspector #548, no post-falls assessment related to resident's #003 fall on a specified date was located. [s. 49. (2)]

***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 the licensee conducts post-fall assessments, to be implemented voluntarily.***

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**Issued on this 12th day of March, 2018**

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

**Original report signed by the inspector.**