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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2018	2018_730593_0017	012261-17, 012766-17, 028998-18	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

GILLIAN CHAMBERLIN (593)

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): November 2, 5 - 7, 13, 2018.

There were four intakes inspected during this inspection: One Critical Incident (CIS) related to an unexpected death, three CIS related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager, Life Enrichment Manager, Registered Dietitian, Registered Nursing Staff, Dietary Staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, resident health care records and reviewed licensee policies.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Légende 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 has failed to ensure that there was a written plan of care for resident #003, that sets out, (c) clear direction to staff and others who provide direct care to the resident.

Inspector #593 reviewed the current documented plan of care for resident #003. The following intervention was documented under the problem- behaviour:
"Two staff for all care due to specific behaviour".

During an interview with Inspector #593, November 7, 2018, PSW #102 indicated that they have provided care for resident #003 for over one year. When asked about providing care for this resident, PSW #102 indicated that they are ok to provide care on their own and the resident has always been ok with one person care.

During an interview with Inspector #593, November 7, 2018, RPN #105 indicated that up until May, 2018, they worked on the same unit as resident #003 and was familiar with this residents care requirements. RPN #105 indicated that this resident was two person care due to specific behaviours from the resident and staff were to provide care in two's.

During an interview with Inspector #593, November 7, 2018, RPN #106 indicated that resident #003 was one person care, unless they had responsive behaviours and then they would require two person care.

During an interview with Inspector #593, November 13, 2018, DOC #104 indicated that resident #003 did not require two person care anymore, sometimes the resident may still require two person care due to responsive behaviours therefore it was left in the plan of care. The plan of care needs to be updated. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

A critical incident report (CIS) was submitted to the Director, reporting the unexpected death of resident #004. It was reported in the CIS that resident #004 started coughing during the dinner meal service after being fed by PSW #102 and later passed away in hospital due to co-morbidities.

During an interview with Inspector #593, November 7, 2018, PSW #102 indicated that they usually served the food however during the dinner meal service prior to resident #004 passing, there were less volunteers to assist with feeding and when they saw that resident #004 was not eating, they stepped in to provide assistance. PSW #102 further indicated that they were standing next to the resident when feeding, as the PSW was moving around also serving residents.

During an observation of the dinner meal service on November 7, 2018, in the first floor West dining room, Inspector #593 observed PSW #102 feeding resident #005 while standing in front of the resident and reaching towards them.

During an interview with Inspector #593, November 13, 2018, DOC #104 indicated that the expectation from the home regarding the feeding of residents, was whoever was feeding the resident, sits right next to the resident and they have to interact one on one, they are watching them swallow as sometimes you think that the resident is ready but they still have food in their mouth. The expectation was that the resident was seated upright and they are observing the resident. They are to make eye contact, it should be one on one, no going from resident to resident. The server should be serving the food. [s. 73. (1) 10.]

Issued on this 10th day of December, 2018

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

Original report signed by the inspector.