Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Apr 30, 2020	2020_665551_0005	002431-20, 002815-20	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

MEGAN MACPHAIL (551)

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 25 and 26 and March 2 and 3, 2020.

The following logs were inspected:
- 002431-20 / Critical Incident Report (CIR) 2882-000003-20 related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
- 002815-20 / 2882-000004-20 related to a missing resident with an injury.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, Life Enrichment Aides, the Physiotherapist, the Staffing Co-ordinator, the Life Enrichment Manager, the Environmental Support Services Manager, a Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed health care records and observed residents' care environments.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 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	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #002.

On a specified date resident #002 exited the home following an activity, unnoticed.

According to Life Enrichment Aide (LEA) #111, they assumed that following the activity, LEA #117 had escorted resident #002 back to their home area.

According to Charge RN #107 approximately one hour after the the activity had ended, the home was notified by paramedics that the resident had been located and was being brought to hospital as per protocol.

Prior to the phone call from paramedics, resident #002 had not been identified as missing from the home.

The home was not a safe and secure environment for resident #002, when on a specified date, they exited the home unnoticed, and staff were not aware that they had left until contacted by the paramedics. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 4th day of May, 2020

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

Original report signed by the inspector.