Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
Feb 3, 2022	2021_548756_0027	015279-21, 015624-21, 017229-21, 017239-21, 019512-21, 000533-22	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 P4R 0A6

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

LISA CUMMINGS (756)

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, 2021, January 5-7, 10-13, 17-19, 2022.

The following intakes were completed as part of the Critical Incident System (CIS) Inspection:
- Log #015279-21 regarding CIS #2882-000017-21, log #015624-21 regarding CIS #2882-000019-21, log #017229-21 regarding CIS #2882-000021-21, log #017239-21 regarding CIS #2882-000022-21, and log #000533-22 regarding CIS #2882-000006-22 that reported allegations of resident abuse and neglect
- Log #019512-21, CIS #2882-000026-21, a fall that caused injury and required a transfer to hospital

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also conducted observations of resident home areas, the provision of resident care and services, and staff and resident interactions. A record review was completed of resident healthcare records including careplans and flowsheets, internal investigation documents including self reports and internal emails and interviews, and of the Resident Falls policy.

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

During the course of this inspection, Non-Compliances were issued.

- **1 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. (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 has failed to ensure that a resident was called their preferred name as specified in the plan of care.

A Critical Incident Report described an allegation that a PSW called a resident a name while providing personal care on one day. The resident's care plan indicated that they should be called by their preferred name, which is their first name. The PSW acknowledged that they may have called the resident a name other than their preferred name but did not mean for it to be disrespectful.

The DOC confirmed that the resident was called a name other than their preferred name.

Sources: Critical Incident Report, Self Report documents, resident healthcare record, and interviews with a PSW, the DOC and other staff. [s. 6. (7)]

Issued on this 8th day of February, 2022

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

Original report signed by the inspector.