Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report
Cover Sheet (A1)

Amended Report Issue Date: June 17, 2024	
Original Report Issue Date: May 16, 2024	
Inspection Number: 2024-1367-0003 (A1)	
Inspection Type: Proactive Compliance Inspection	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Garden Terrace, Kanata	
Amended By Pamela Finnikin (720492)	Inspector who Amended Digital Signature Pamela Finnikin (720492)

AMENDED INSPECTION SUMMARY

This report has been amended:

NC #001 remedied was amended to reflect the Administrator's stated corrective actions to the identified non-compliance on a specific date in April 2024. This non-compliance was determined remedied by Inspector #740785 the next day in April 2024.
NC #004 WN was amended to reflect the correct year for the 2022 CQI report.

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Lead Inspector Pamela Finnikin (720492)	Additional Inspector(s) Severn Brown (740785)
Amended By Pamela Finnikin (720492)	Inspector who Amended Digital Signature

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9-12, 15-17, 2024.

The following intake(s) were inspected:

- Intake: #00113111 - Proactive Compliance Inspection

The following Inspection Protocols were used during this inspection:

Admission, Absences and Discharge
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Resident Care and Support Services
Residents' and Family Councils
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the home's current version of the visitor policy was posted in the home.

Rationale and Summary

During the initial tour of the home conducted by Inspector #740785 in April 2024, the inspector did not observe the home's visitor policy posted in the home in a conspicuous area accessible to residents and visitors. The inspector confirmed that the home's visitor policy was not posted with the Office Manager. Administrator confirmed that the home's visitor policy was not posted in the home on the specific date in April 2024. Administrator further stated that the home's visitor policy was posted immediately in the home after being made aware by inspector #740785.

The next day, the inspector observed the current version of the home's visitor policy posted in the front entrance of the home.

Sources: Observations for mandatory postings in the home in April 2024, and interview with Administrator.

[740785]

Date Remedy Implemented: April 10, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provide direct care to the resident.

Rationale and Summary

A resident's care plan, dated April 2024, states that the resident is to be checked at least every two hours related to continence care. The resident's Kardex as of April 2024 states that the resident is to be provided continence care as necessary. Resident's documentation summary for April 2024 indicates that the resident is to be checked for continence care every shift. A PSW stated that the resident is able to communicate if they require continence care and that the resident does not need to receive continence care checks every two hours. An RPN stated that the resident is able to communicate to staff related to their continence care needs and do not require continence checks every two hours.

By not ensuring that staff are provided clear direction for the resident's plan of care,

the resident is placed at risk of having inconsistent continence care.

Sources: Resident's Care Plan, Kardex, and documentation summary from April 2024 and interviews with a PSW and a RPN.

[740785]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that staff documented resident's care as set out in their plan of care.

Rationale and Summary

The resident's care plan states that they are on a scheduled toileting plan and they are to be toileted every two hours, and as required. The resident's documentation summary from their electronic chart for April 2024, has no documentation for a specific date in April 2024 under bladder toileting, bowel toileting, and toilet use for two days in April 2024.

A PSW stated that the resident is on a toileting schedule and they need to toilet them according to that schedule. The Administrator stated that any residents on a toileting program must have their toileting documented in their electronic chart.

By not ensuring that the resident's toileting was documented as required by their plan of care, the resident's toileting status is put at risk of not being communicated to other staff members, putting the resident at risk of sub-optimal care.

Sources: The resident's care plan and April 2024 electronic documentation survey, and interviews with a PSW and Administrator.

[740785]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee has failed to ensure that a Continuous Quality Improvement (CQI) Resident and Family/Caregiver Experience survey was conducted in 2022.

Rationale and Summary

Inspector #740785 was not provided a copy of the home's 2022 CQI Resident and Family/Caregiver Experience Survey results upon request. the Administrator, who is the home's designated CQI lead, stated that no Resident and Family/Caregiver Experience Survey was conducted in 2022.

By not ensuring that a Resident and Family/Caregiver Experience Survey was conducted in 2022: residents, families, and caregivers were put at risk of not having an opportunity to communicate their satisfaction levels with the home and the care, services, programs and goods provided at the home.

Sources: Electronic communication with the Administrator in April 2024, and an interview with the Administrator.

[740785]

WRITTEN NOTIFICATION: Doors in the Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-resident areas are kept closed and locked when not supervised by staff.

Rationale and Summary

In April, 2024, inspector #740785 observed that a door on the ground floor and accessible to residents labelled "Fire Panel Room" was partially open, unsupervised by a staff member, and was not equipped with a lock.

The Administrator stated that the door to the Fire Panel Room must be kept locked and is a non-resident area.

By not ensuring that a door to a non-resident area was kept closed and locked when not in use, residents were placed at risk of entrapment and potential injury.

Sources: Observation of Fire Panel Room in April 2024, and interview with the Administrator.

[740785]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

As a required program, O. Reg. 246/22 s. 74 (2) (a) required the licensee to have a nutritional care and dietary services and hydration program with programs and procedures developed and implemented within the home to meet the daily nutrition needs of the residents.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation required

the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the policy titled Temperature Danger Zone Corrective Actions Policy #: NC-FS-4.8 (Reviewed on September 14, 2022) which was included in the licensee's Nutritional Care and Dietary Services Program.

Rationale and Summary

Temperature Danger Zone Corrective Actions Policy #: NC-FS-4.8 Reviewed on September 14, 2022 states on page one that temperatures are to be taken and recorded on the Production Sheet at three different stages to ensure safe food handling techniques.

Review of temperature logs for the second floor east and west units confirm that breakfast temperatures were not taken on a specific date in April 2024.

An interview conducted with Nutritional Manager confirmed that temperature logs during meal services are mandatory as per the policy and that this was not done for breakfast on the second floor east and west units on a specific date in April 2024.

By not recording food temperatures, the licensee does not have documentation to support that residents were served foods that were safe and palatable.

Sources: Temperature Danger Zone Corrective Actions Policy #: NC-FS-4.8, observations and temperature log reviews, and an interview with the Nutritional Manager and others.

[720492]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to residents.

Rationale and Summary

In April 2024, Inspector #720492 observed staff on second floor east unit serving residents frozen Jell-O for dessert at lunch time and stating the Jell-O was frozen to family and residents prior to serving it.

The resident notified Inspector #740785 in an interview in April 2024 about the Jell-O being served frozen at lunch time on the same day. The resident also stated that resident concerns about frozen desserts were brought forward to the management team at the Resident Council Meeting on March 28, 2024.

Resident Council Meeting Minutes for March 28, 2024 were reviewed by Inspector #740785 and it was documented that there were concerns related to desserts such as Jell-O being served frozen to residents at meal times.

Interview with the Nutritional Manager (NCM) confirmed that the nutrition team was notified about residents being served frozen desserts from the Resident Council Meeting. The NCM stated that staff are expected to check the temperature of all food prior to serving residents, that staff were made aware of the concerns brought forward by the Resident Council Meeting in March and that serving frozen Jell-O during lunch time on a specific date in April 2024 was not acceptable.

Failure to ensure that residents were served food and fluids at palatable temperatures, put the residents at increased risk of not enjoying the dining experience and/or experiencing unplanned weight loss which could lead to physical and psychological harm.

Sources: Resident Council Meeting Minutes from March 28, 2024, interviews with NCM and residents.

[720492]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff fully participate in the implementation of

the home's infection prevention and control (IPAC) program.

Rationale and Summary

During the initial tour of the home conducted by inspector #740785 in April 2024, the inspector observed staff members unmasked in a resident common area.

During an interview with inspector #720492, the IPAC Lead stated that all staff must be masked in resident areas. The Administrator also stated that staff are to be masked in all resident areas, including staff contracted by the home.

By not ensuring that all staff participate in the home's IPAC program, residents are put at increased risk of contracting a communicable disease.

Sources: Observation by the inspector, and an interview of the IPAC Lead by inspector #720492 and the Administrator.

[740785]