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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2014	2014_200148_0007	0-000147-14	Complaint

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 25 and 26, 2014, on site.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Personal Support Worker (PSW) Students and representatives of a specified private career college.

During the course of the inspection, the inspector(s) reviewed the home's agreement with a specified private career college for the placement of students and email communications related to this complaint.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.76 (2,) whereby the licensee failed to ensure that staff are provided orientation training, prior to performing their responsibilities as outlined by this provision.

As defined by the LTCHA 2007, staff include persons who work at the home, pursuant to a contract or agreement with the licensee. Staff who work in the home pursuant to a contract or agreement with the licensee and who provide direct care to residents are not exempt from the requirements of section 76 of the Act.

On February 10, 2014, the home began a four week placement of PSW Students from a private career college. It was confirmed that from February 11, 2014, through to this inspection date, PSW Students were involved in the provision of direct care to residents. The PSW Students are working in the home pursuant to an agreement.

During an interview with the home`s DOC and Administrator it was indicated that orientation time had been provided to the students on two separate occasions that included tours of the home, introduction to staff members and an overview of specific home policies and programs. Students are informed of the location of required postings, such as the home`s abuse policy and additionally that the home's policies may be accessed in binders at the nursing stations on each floor. Through a subsequent interview, the Inspector reviewed the requirements of section 76 of the Act. At this time the DOC indicated that orientation to all aspects of the requirements under section 76 of the Act are not provided and that she was not aware that students required such orientation.

On February 26, 2014 the Inspector spoke with a group of PSW Students in the home, with the Clinical Instructor and Educational Director for the private career college present. It was determined that the students had not been provided with the orientation required by section 76 of the Act, prior to performing their responsibilities. PSW Students were not able to explain the duty of mandatory reporting or the protections afforded under section 26 of the Act.

The licensee has not ensured that all staff, including PSW Students who provided direct care to residents, are provided with orientation as required under section 76 of the Act. [s. 76. (2)]

Issued on this 3rd day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Amanda Nixon RD LTCH Inspector