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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2016	2016_396103_0020	018148-16	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

WEST LAKE TERRACE
1673 COUNTY ROAD, 12 R. R. #1 PICTON ON K0K 2T0

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

DARLENE MURPHY (103)

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): June 21, 22, 24 and 28, 2016

During the course of the inspection, the inspector(s) spoke with a resident, Registered Practical Nurses, Registered Nurses, the Life Enrichment Coordinator, the Director of Care, the Administrator and the Director of Operations.

During the course of the inspection, the inspector reviewed a resident health care record, and home policies related to complaints and volunteers.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Reporting and Complaints
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision maker (SDM) and any other persons designated by the resident or SDM were given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001's health care record was reviewed and indicated the resident had resided in the home since an identified date and included identified diagnoses. The Administrator was interviewed and indicated resident #001 frequently approached him with a variety of concerns. The Administrator indicated he believed the resident was capable of making their own decisions and that he advocated for the resident in a number of areas. He indicated several months earlier, resident #001 approached him and wanted to engage in outside activities with #105 and the Administrator facilitated this request. The family of resident #001 became aware of these activities and expressed concern to both the Administrator and the OMNI head office that they had not been consulted in this decision.

The family raised safety concerns about the activities and stated the resident was vulnerable and may lack the appropriate judgement in this new situation. In addition, the family was seeking information related to the person involved in the outside activities with resident #001. The family were advised by the Administrator that resident #001 was capable of making the decision and the family member's consent was not required to do so. The family reported being taken off guard by the decision and expressed they would have appreciated being involved as they had always maintained a close relationship with resident #001.

The resident plan of care in effect at the time of this inspection was reviewed and identified memory and decision making issues and resident behaviours. The Administrator was interviewed in regards to the behaviours identified in the care plan. He indicated these behaviours were no longer an issue and that he had followed up with #105 to ensure there was no evidence of these behaviours during the activities. Progress notes documented on an identified date were contrary to this and indicated co-residents had raised concerns to staff related to resident #001's statements about #105. The inspector interviewed resident #001 who relayed similar statements related to #105. [s. 6. (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 the SDM's and any other person designated by the resident or SDM are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure policies related to the use of volunteers in the home were complied with.

LTCHA, 2007, s. 16 states every licensee of a long term care home shall ensure there is an organized volunteer program for the home. In accordance with O. Reg 79/10, s. 30, all organized programs must include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

The home failed to ensure all volunteers associated with the home have the required orientation and background checks in accordance with the home's policies. The inspector interviewed the Life Enrichment Coordinator (LEC) who indicated #105 did conduct volunteer services in the home but did not receive orientation or complete a background check.

The home's policy titled, "Volunteer Recruitment, Selection and Orientation", LE-5.3, last updated January 2014, was reviewed. Under Orientation Procedure, it indicates the following:
-every individual expressing interest in volunteering in the home shall be given a volunteer application form and be asked to complete it,
-the applicant shall be provided the applicable forms to obtain a Criminal Record and Vulnerable Sector Screening to take to the local police station,
-upon receiving confirmation that the applicant volunteer does not have a criminal record, the Life Enrichment Coordinator shall schedule an orientation session,
-a volunteer file shall be established for each new volunteer and maintained for the duration of their service to the home.

The home failed to ensure policies were complied with related to volunteer orientation, criminal record and vulnerable sector screening and community outings. [s. 8. (1)]

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 the policies and procedures in place for volunteers are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints that have been received concerning the care of a resident or the operation of the home was submitted to the Director.

The Administrator was interviewed in regards to written and verbal complaints received by the home. The Administrator indicated there have been no verbal or written complaints since 2011. The Administrator was asked if emails would be considered written complaints and he indicated they would.

On an identified date, the Administrator and the Chief Executive Officer (CEO) of OMNI Health Care received emails from resident #001's family member outlining concerns related to the care of the resident. On an identified date, the CEO received an email outlining concerns related to the Administrator allegedly harassing resident #001. On four identified dates, the Director of Operations received emails related to the care of resident #001. On an identified date, the Administrator received a letter outlining concerns related to the care of resident #001. To date of this inspection, these emails or letters were not forwarded to the Director. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes all verbal and written complaints.

To date of this inspection, the home has no entries in the documented record for 2015 and 2016 to reflect the written complaints outlined in WN #3. [s. 101. (2)]

Issued on this 7th day of July, 2016

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

Original report signed by the inspector.