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
Jan 25, 2022	2022_505103_0002	016821-21, 020582-21	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

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 20-21, 2022.

Log #016821-21 (CIS #0997-000008-21)-alleged incident of improper/incompetent treatment of a resident,
Log #020582-21 (CIS #0997-000010-21)-alleged incident of resident financial abuse.

During the course of the inspection, the inspector(s) spoke with residents, a Housekeeper, a Registered Practical Nurse (RPN), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector made resident and staff observations related to infection, prevention and control, resident care, dining and activities, and reviewed resident health care records, the critical incidents submitted to report the alleged incidents and the home's investigation into the incidents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The person who had reasonable grounds to suspect a resident had been financially abused failed to immediately report the suspicion and the information upon which it was based to the Director.

A resident reported to an RPN that they were missing money. The RPN notified the Administrator by email to advise them of the incident, but the Administrator did not receive the email until the following day. The Administrator stated the RPN should have notified them by telephone such that immediate notification of the Director could have occurred.

Sources: Critical incident and interview with the Administrator. [s. 24. (1)]

2. The persons who had reasonable grounds to suspect a resident had received improper/incompetent care failed to immediately report the suspicion and the information upon which it was based to the Director.

A resident had a treatment completed by staff members without a physician's order and that was outside of their scope of practice. The DOC stated neither staff member identified any concerns related to this action at that time, however in the following days, additional PSW staff became aware of the incident and despite having concerns, failed to immediately report the incident to management staff. The DOC stated they did not become aware of the incident until five days later. The DOC stated they believed the incident constituted incompetent care and staff that subsequently became aware of the incident should have immediately reported their concerns.

Sources: Critical incident and interview with the Director of Care. [s. 24. (1)]

Issued on this 26th day of January, 2022

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

Original report signed by the inspector.