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: August 17, 2023
Original Report Issue Date: July 11, 2023
Inspection Number: 2023-1019-0003 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: West Lake Terrace,Picton

Amended By	**Inspector who Amended Digital Signature**
Wendy Brown (602)	Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.08.18 16:11:08 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to include reference to legislation: **Non-compliance with: O. Reg. 246/22, s. 161. (2) (c) -** Before discharging resident #001, the licensee failed to ensure the resident and the resident's POA were given an opportunity to participate in discharge planning and that their wishes were taken into consideration.

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Long Term Care Home and City: West Lake Terrace, Picton	
Lead Inspector Wendy Brown (602)	**Additional Inspector(s)**
Amended By Wendy Brown (602)	**Inspector who Amended Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.08.17 16:31:59 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to include reference to legislation: **Non-compliance with: O. Reg. 246/22, s. 161. (2) (c) -** Before discharging resident #001, the licensee failed to ensure the resident and the resident's POA were given an opportunity to participate in discharge planning and that their wishes were taken into consideration.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27-29, 2023

The following intake(s) were inspected:

- Intake: #00086490/CIS #0997-000009-23 - regarding a fall with injury requiring transfer to hospital.
- Intake: #00089281/CIS #0997-000014-23 - Alleged resident to resident physical abuse.
- Intake: #00089542 /Complaint regarding communication and inappropriate discharge from the home.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

Rationale & Summary:
A resident had an unwitnessed fall and was transferred to hospital for further assessment. The resident sustained fractures to the pelvis and a hip joint. A review of the care plan and kardex indicated the resident was bedfast, was not to be transferred, was unable to ambulate and required toileting while in bed. The resident was observed ambulating with a walker and assist of one staff on multiple occasions throughout the inspection. In addition, there was no transfer logo noted above the bed despite interviews with a Registered Nurse (RN) and a Personal Support Worker (PSW) who indicated that logos were to be changed to indicate transfer status for reference by staff caring for the resident. Unclear direction regarding mobility and transfer status could place the resident at an increased risk for falls.

Sources:
Resident electronic and hard copy health record, a Critical Incident System (CIS) report, multiple observations, interviews with a RN, PSW and other staff. [602]

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 30 (1) (a)

The licensee failed to ensure that care conferences of the interdisciplinary team providing care for two residents were held within six weeks following their admission to discuss the plan of care and any other matters of importance to the residents and their substitute decision-maker/power of attorney (POA).

Rationale and Summary:
Reviews of resident electronic health records found no documentation specific to two residents' six-week care conferences. Interviews and further review of the residents' health care records with the Infection Prevention and Control (IPAC) lead/RAI Coordinator indicated there was no six-week care conference completed for either resident.

Failure to complete the six-week care conferences did not allow for essential communication and necessary care planning for two residents.

Sources:
Electronic and hard copy chart review for four residents, interviews with a resident's POA, the IPAC lead/RAI-Coordinator, and the Administrator.[602]

WRITTEN NOTIFICATION: Operation of Homes

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee failed to ensure that before performing their responsibilities a PSW received training in the areas mentioned below:

- Residents' Bill of Rights.
- Long-Term care (LTC) home's mission statement.
- LTC home's policy to promote zero tolerance of abuse and neglect of residents.
- Duty under section 28 to make mandatory reports.
- Protections afforded by section 30.
- LTC home's policy to minimize the restraining of residents.
- Fire prevention and safety.
- Emergency and evacuation procedures.
- Infection prevention and control.
- All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
- Any other areas provided for in the regulations.

Rationale and Summary:
In an interview a newly hired PSW working in the home, indicated they had not yet completed the training required as part of their orientation. The IPAC lead/RAI Coordinator acknowledged in an interview and confirmed in email documentation that this staff had not completed any of their surge learning education required by the licensee as part of orientation.

Sources:
PSW surge learning education status report, email documentation, interviews with a PSW and the IPAC lead/RAI Coordinator. [602]

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with their written policy related to falls prevention and management for a resident.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their written policy related to falls prevention and management for residents is complied with.

Specifically, staff did not comply with the resident's falls assessment procedure: If any possibility of a head injury, check pupil reaction: complete head injury routine (HIR).

Rationale and Summary:
A resident sustained an unwitnessed fall in their bedroom; they were discovered lying on the floor. On assessment they were noted to be unable to move their a leg without significant pain; initial neurological vital signs were noted. The resident was transferred to hospital for assessment; the resident was not admitted to the hospital. A chart review completed with the IPAC lead/RAI-Coordinator found that the remaining neurological vital signs/HIR were not completed on return to the home.

Failure to complete HIR assessments following an unwitnessed fall posed a risk to the resident as they were not monitored for neurological symptoms after sustaining a possible head injury.

Sources:
Resident electronic and hard copy health records, a CIS report, Resident Falls and Post Fall Assessment Policy, interviews with IPAC lead/RAI-Coordinator and the Administrator. [602]

WRITTEN NOTIFICATION: Discharge

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (1) (a)

The licensee failed to ensure that, before resident #003 was discharged, notice of the discharge was given to the resident and/or the resident's substitute decision-maker/POA, as far in advance of the discharge as possible.

Rationale and summary:
In an interview regarding a resident to resident abuse incident, a RN indicated that a resident began to exhibit inappropriate behaviours and attempts by staff to redirect the resident resulted in escalation of the resident's behaviours. The resident pushed a co-resident and would not leave the co-resident's room despite staff requests. The home's physician was informed and suggested that staff administer ordered PRN medication(s); the resident refused. The physician noted that recent medication change(s) as well as withdrawal issues may have contributed to resident behaviours.

Contact was made with resident's POA who was asked to come in to try to calm the resident. As the POA's attempts to deescalate the resident's behaviours were also unsuccessful, and co-resident and staff safety remained a concern, the resident was taken to hospital where they were admitted for assessment and treatment.

The CI report indicated that the resident had previous documented episodes of altercations with others, however, there had been no deliberate physical aggression toward their co-residents until this incident. Interviews with a RN and the Administrator confirmed previous incidents were verbal or unintended.

A letter authored by the Director of Care (DOC) was sent to the resident's POA three days after the incident indicating that the resident had been formally discharged.

Discharging a resident prior to notification of their POA can result in delays in securing appropriate placement.

Sources:
A CIS report, a discharge letter, email documentation with Home and Community Care Support Services (HCCSS) – placement facilitator, resident progress notes, and interviews with the Administrator, a RN, the POA, and the HCCSS – placement facilitator.

WRITTEN NOTIFICATION: Discharge

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (a)

The licensee failed to ensure that alternatives to discharge were considered and, where appropriate, tried, before a resident was discharged.

Rationale and Summary:
The DOC sent a letter to a resident's POA indicating that the resident had been formally discharged following an incident that occurred three days prior.

In an interview with the Administrator, it was acknowledged that there had been no discussion regarding alternatives to discharge attempted despite the resident's challenging behaviours e.g., external consults and/or care conferences.
Discharging a resident prior to considering alternatives can result in delays in arranging discharge alternatives and or securing appropriate care, supports and/or accommodation(s).

Sources:
A CIS report, a discharge letter, email documentation with HCCSS – placement facilitator, resident progress notes, and interviews with the Administrator, the POA, and the HCCSS – placement facilitator. [602]

WRITTEN NOTIFICATION: Discharge

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)

The licensee failed to collaborate with the appropriate placement co-ordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by a resident prior to discharge.

Rationale and Summary:
A resident was formally discharged from the home following an incident; email documentation indicates that HCCSS – Placement was alerted on three days after the incident. In interviews with the Administrator, it was acknowledged that there had been no attempt to make alternative arrangements for the accommodations, care and secure environment required by the resident prior to discharge.

Sources:
A CIS report, a discharge letter, email documentation with HCCSS – placement facilitator, resident progress notes, and interviews with the Administrator, the POA, and the HCCSS – placement facilitator.

WRITTEN NOTIFICATION: Discharge

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)

The licensee failed to ensure a resident and the resident's POA were given an opportunity to participate in discharge planning and that their wishes were taken into consideration.

Rationale and Summary:
A resident was formally discharged from the home, as evidenced by a letter dated three days after an incident. In an interview with the Administrator, it was acknowledged that there had been no

opportunity provided for the resident and/or POA to participate in discharge planning and that their wishes were not identified or taken into consideration prior to discharge.

Sources:
A CIS report, a discharge letter, email documentation with HCCSS – placement facilitator, resident progress notes, and interviews with the Administrator, the POA, and the HCCSS – placement facilitator.[602]