Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2015	2015_225126_0019	O-001965-15	Resident Quality Inspection

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

FOREST HILL
6501 CAMPEAU DRIVE KANATA ON K2K 3E9

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

LINDA HARKINS (126), HUMPHREY JACQUES (599), LISA KLUKE (547), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 11-15 and May 19-22, 2015

During this inspection, two complaints and four critical incidents inspections were conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Nutritional Care Manager, the Life Enrichment Manager, several Registered Nursing Nurses, several Registered Practical Nurses, several Home support Workers, several residents, the President of the Resident Council, the President of the Family Councils and several families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

2 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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 20017, S.O. 2007, s.6. (7) in that the licensee did not ensure that plan of care wast provided to the resident as specified in the plan.

On a specific date in November 2014, Resident # 17 was found on the toilet by an evening Personal Support Worker at the start of her shift. Resident # 17 was transferred to the toilet and was left unattended by the day staff. Resident # 17 was assessed and was noted to have a red bottom at that time. No complaint of pain and no other injury noted. Following the home's investigation,it was determined that Resident # 17 was left on the toilet unattended for a period of approximately 1 hour.

Resident # 17 care plan dated October 27, 2014 was reviewed and it was noted that Resident # 17 required 2 staff providing extensive assistance with entire toileting procedure.

Discussion held with the Director of Care, indicated that day staff PSW # 122 involved in this incident came forward and indicated that she " forgot " the resident on the toilet because she had to attend an emergency situation and that she did transferred Resident # 17 on her own. The DOC indicated that reeducation was done with this PSW. The home followed their process and immediately notified the Ministry of Health Director and notified the resident's Power of Attorney of the above incident.

The PSW # 122 did not provide care to the resident as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that call bell system are in a good state of repair.

The home uses a Vigil resident-staff communication and response (call bell) system which includes a call cancel station (wall panel) at the resident's bedside and an emergency call cancel station (wall panel) in the resident's washroom. At the bedside, the call bell is activated by pushing a red button at the end of the call bell cord or by pushing a green colored call button on the call cancel station. In the washroom, the call bell is activated by lowering a red button on the emergency call cancel station.

When the call bell is activated a green colored light (signaling that the call is coming from the room) or red colored light (signaling that the call is coming from the washroom) flashes in the corridor outside of the resident's room, and the room number or washroom from which the call is coming from registers to a pager that is carried by the PSWs.

The following observations illustrate that when activated the call bell system did not clearly indicate where the signal was coming from and was not in a good state of repair:

Room 251-A, on May 13, 2015: When the call bell at the bedside was activated, the light in the corridor did not flash, and the call did not register to the pager.
Room 240-A, on May 13, 2015: When the call bell at the bedside was activated, the call did not register to the pager, but the light in the corridor flashed.
Room 255-A and 255-B, on May 12, 2015: When the call bell was activated at both bedsides, the call did not register to the pager, but the light outside of the room flashed.
Room 237-A and 237-B, on May 12, 2015: When the call bell was activated at both bedsides and in the shared washroom, the lights outside of the room did not flash, but the call did register to the pager. In an interview with the Maintenance Manager, he indicated the dim board for the light was not illuminating and that a part had been ordered.

Room 237-A, on May 20, 2015: When the call bell was activated at the bedside, the call did not register to the pager, and the part for the dim board for the light remained on order therefore the light did not flash in the corridor. The Maintenance Manager was informed of this observation, followed up and reported that when the call bell at the bedside of 237-A was activated, the call was registering to the pager.
On May 20, 2015, the call bells at the bedside and in the washroom of rooms 240-A, 251-A, 255-A, 255-B, 237-B were activated and indicated where the signal was coming from with flashing lights and by registering to the pager. [s. 15. (2) (c)]

Issued on this 27th day of May, 2015

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

Original report signed by the inspector.