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

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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
Jun 24, 2016	2016_286547_0015	020469-15/022632-15/003874-16/008109-16	Critical Incident System

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

FOREST HILL
6501 CAMPEAU DRIVE KANATA ON K2K 3E9

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

LISA KLUKE (547)

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): June 15, 16, 17, 20, 21, 22, 2016

The purpose of this inspection was related to a critical incident the home submitted log #020469-15 related to an altercation between two residents, log #022632-15 related to staff to resident abuse, log #003874-16 related to restraints and plan of care and a complaint log #008109-16 related to lifts and transfers.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers(PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Services Coordinator (RSC), Physiotherapist (PT), and Physiotherapy Assistant (PTA), Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.
In addition the inspector reviewed: resident health care records, documents related to the home's investigations into specified critical incidents reported by the home, policies related to restraint use, lifts and transfers, restraints, abuse prevention, conflict resolution guidelines, education and re-education material provided by the home to nursing staff related to these issues, staff work routines and schedules and the inspector observed aspects of resident care and interactions with staff.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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 ensure that the care set out in the plan of care regarding application of a lap belt restraint, was provided to resident #008 as specified in the plan.

Resident #008 was admitted to the home with several diagnoses including a cognitive impairment and was assessed as risk for falls. Resident #008 was prescribed the application of a lap belt restraint while seated in a wheelchair as the resident's Substitute Decision Maker (SDM) requested use of wheelchair for mobility and a lap belt to decrease the risk of the resident getting up on his/her own.

On a specified date, resident #008 was being prepared for lift transfer by PSW #101 for toileting purposes before having a nap. PSW #101 applied the toileting sling to the resident and then left the room to go find PSW #102 for assistance. PSW #101 was called off the unit for a meeting while waiting for PSW #102 and left the floor leaving resident #008 alone in his/her bedroom with the toileting sling applied. PSW #102 indicated to Inspector #547 that she was busy with another resident on the floor when PSW #101 was looking for her assistance for resident #008 and that PSW #101 then informed PSW #102 that she was leaving the floor for a meeting. PSW #102 completed the care required for the other resident and returned to the hallway where a specified person at the end of the hallway was helping resident #008 onto a walker. The specified person reported to PSW #102 that she had found resident #008 stuck in the doorway trying to manoeuvre between the door frame and the mechanical lift that was stuck in the doorway with the toileting sling hanging off the resident's shoulders. The specified person indicated that she grabbed the closest piece of equipment she could to sit the resident down for safety in the hallway. The resident's wheelchair was noted by PSW #102 to be located beside the bed inside his/her bedroom.

Inspector #547 reviewed resident #008's health care records including the care plan from specified date utilized during the period of this incident which identified that nursing staff are to apply the resident's lap belt when in the resident's wheelchair for safety to prevent falls and to ensure that the lap belt is applied properly.

On June 17, 2016 PSW #101 indicated to Inspector #547 that on this specified date, that she had prepared the resident for lift transfer at the resident's bedside and then had to leave the resident's bedroom to get another PSW for assistance. PSW #101 indicated to Inspector #547 that she could not confirm that she had re-fastened the resident's lap belt restraint after having placed the toileting sling behind resident #008 in preparation of lift transfer. PSW #101 indicated that she was aware that resident #008 required a lap belt to be tied at all times while seated in his/her wheelchair when left unattended by staff.

On June 20, 2016 the DOC indicated to Inspector #547 that a review with PSW #101

about the home's expectations with policies and procedures regarding lifts and transfers, attention to duties and that PSW #101 was to review resident's individualized plans of care prior to providing care. Resident #008's care plan stated that the resident required a seat belt at all times when sitting in his/her wheelchair and never leave a resident alone in a wheelchair unsupervised without a seat belt. [s. 6. (7)]

Issued on this 24th day of June, 2016

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

Original report signed by the inspector.