Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2019	2019_520622_0024	016054-19	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

Forest Hill
6501 Campeau Drive KANATA ON K2K 3E9

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

HEATH HEFFERNAN (622)

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): October 8, 9, 10, 2019

The following logs were completed during this inspection:

Log #016054-19/Critical Incident System report (CIS) #2834-000020-19 related to an incident that caused injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), The Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

Also during the course of the inspection, the inspector reviewed the critical incident system reports (CIS), electronic and hard copy health records, registered and non-registered staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions related to the use of a seat belt for resident #001 to staff and others who provide direct care to the resident.

Critical Incident System report (CIS) #2834-000020-19, indicated on a specified date, resident #001 had an unwitnessed fall and sustained an injury.

During observation of resident #001 on October 8, 2019, inspector #622 observed resident #001 on two occasions to be in their wheelchair, and not wearing their seat belt.

On October 8, 2019, inspector #622 reviewed the physician's orders for a specified date, which stated that resident #001 was to use a tilt wheelchair and seat belt.

On October 8, 2019, inspector #622 reviewed the most recent nursing care plan and Kardex which did not include direction for the use of a seat belt for resident #001. The most recent physiotherapy care plan stated that resident #001's substitute decision maker would like resident #001 to wear a seat belt to prevent falls.

On October 8, 2019, inspector #622 reviewed the current Point of Care (POC) flow sheets which did not include direction for resident #001 to wear a seat belt.

On October 8, 2019, inspector #622 reviewed the documentation on the electronic medication administration record (eMAR) for two specified months. The eMAR documentation had not been updated to include direction for resident #001 to wear a seat belt until 25 days after the physician's order was received.

During separate interviews with inspector #622 on October 8, 2019, Personal Support Worker (PSW) #103 stated that they would follow direction for resident care requirements on POC. PSW #103 was not aware of the care requirement for resident #001 to use a seatbelt at all times when up in their wheelchair. PSW #103 stated that the seat belt was only to be used when resident #001 required it.

Registered Practical Nurse (RPN) # 101 stated that resident #001's seat belt was to be used pro re nata (PRN) and they did not feel resident #001 required it. RPN #101 reviewed the physician's order dated on the specified date, which stated that resident

#001 was to use a tilt wheelchair and seat belt. RPN #101 said according to the physician's order, resident #001 should always have their seat belt on when in their wheelchair.

On October 9, 2019, RPN #101 informed inspector #622 that the physician's order dated for the specified date for resident #001's seat belt had not been documented to the eMAR, care plan, or POC until 25 days after the order was received.

During an interview with inspector #622 on October 9, 2019, RN #102 stated that the direction for resident care would be found in the care plan and on POC. RN #102 stated that when the order for resident #001's seat belt was received on the specified date, the nurse should have documented it on the eMAR, POC, and updated the care plan, in this case, documentation of the order had not been completed. RN #102 further stated that since the order for resident #001's seat belt was not communicated to the care plan, eMar and POC, the plan of care did not offer clear direction to the staff who provided care to resident #001. [s. 6. (1) (c)]

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 every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,, to be implemented voluntarily.

Issued on this 17th day of October, 2019

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

Original report signed by the inspector.