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 16, 2016	2016_380593_0017	009411-16, 031857-15, 035564-15	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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

GILLIAN CHAMBERLIN (593)

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 13 - 15, 2016

Three critical incidents were inspected during the inspection including log #009411 -16 related to alleged resident theft, log #031857-15 related to suspected resident to resident physical abuse and log #035564-15 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home is restrained by the use of a physical device, other than accordance with section 31 or under the common law duty described in section 36 [log #035564-15].

A Critical Incident (CI) was submitted by the home related to an incident where PSW #100 put resident #003 in bed, raised both the head and the foot of the bed and left the room. PSW #101 was walking down the corridor and heard the resident screaming for help. PSW #101 opened resident #003's door and found the resident in a very uncomfortable position with both their head and legs elevated and believed that this was done to prevent the resident from getting up. When PSW #101 reported to PSW #100 that he had helped resident #003 out of bed, PSW #100 seemed upset with this.

A review of the home's documented investigation found a description of the events as reported by PSW #101: PSW #101 was walking down the hallway and could hear a resident screaming for help. PSW #101 said that resident #003's door was almost completely closed but was prevented from fully closing because of a hanger on the door. PSW #101 opened the resident's door and saw the resident in a very uncomfortable position with both their legs and head elevated as high as the bed could go in both

directions. PSW #101 said the resident was compressed and that they were having serious breathing issues and that they were trying to jump out of the bed but couldn't move and was gasping. PSW #101 stated that resident #003 could not reach their call bell. After assisting resident #003, PSW #101 told PSW #100 what he had done and she was very angry with him. She exclaimed "why did you do that?", "I can't keep the resident in one place".

A review of resident #003's care plan at the time of the incident, found that the resident was a high risk of falls with several interventions in place. There were no interventions documented for resident #003 that involved the use of any type of physical restraint.

During an interview with Inspector #593, June 14, 2016, PSW #101 reported that the evening of the incident as he was going to answer a callbell, he heard a resident screaming for help. PSW #101 reported that he entered resident #003's room and saw them in bed with the head and the foot of the bed raised to the maximum. He added that they were compressed in the middle and this was causing them difficulty with breathing. PSW #101 reported that resident #003 told him that they were having trouble breathing and could not move. After he tended to the resident, PSW #101 approached PSW #100 about the incident. PSW #101 reported that PSW #100 actually admitted to raising the resident's legs and head to prevent them from moving.

During an interview with Inspector #593, June 15, 2016, the Administrator reported that PSW #100's employment was terminated as a result of this incident.

A review of the home's policy # CS-5.1 Least Restraint, Last Resort, effective date June 2014, found that a restraint shall not be used under any of the following circumstances: because the resident cannot be adequately observed, to control any behaviour that is not a serious risk to the resident or others, before all appropriate alternatives have been considered or trialed, in a non-imminent situation without the consent of the residents SDM, for the convenience of staff or as a disciplinary measure.

As reported by PSW #101, resident #003 was purposely restrained in bed in a position that was uncomfortable, they could not move from and caused trouble with breathing. It was unknown how long the resident was in this position. Furthermore, it was reported by PSW #101 that PSW #100 admitted to putting resident #003 in that position so that she could not move out of bed. The resident was restrained by the staff with the use of a physical device that was not in accordance with the LTCH Act 2007 or with the home's physical restraint policy. [s. 30. (1) 3.]

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 ensuring that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36 and that the use of any physical restraint, is done so in accordance with the requirements set out in the LTCH Act 2007, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of resident's, was complied with [log #035564-15].

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents- #AM - 6.9", effective date June 2015, found that a person who has reasonable grounds to suspect that any of the following has occurred or may occur is required by the Long Term Care Homes Act to immediately report the suspicion and the information upon which it is based to the Director: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. Furthermore, any person who has reasonable grounds to suspect that a resident has been neglected or abused is obliged by law to immediately report the suspicion and the information upon which it is based to the Director, Home's Administrator or manager on call.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of reported staff to resident abuse. It was reported by PSW #101 that they found resident #003 in bed with both the head and the foot of the bed raised. The resident was having trouble breathing and could not get out of the bed. PSW #101 reported the incident to the management of the home as they believed PSW #100 left resident #003 in the position to prevent the resident from getting out of bed.

PSW #101 did not report the incident to the management of the home until five days after the incident occurred. This was the same day that the CI was submitted to the MOHLTC.

During an interview with Inspector #593, June 14, 2016, PSW #101 reported that they did not report the incident immediately as it was the weekend and also they were hesitant because it was very hard to report somebody because he knew that this would hurt them and that their relationship would be disturbed. When asked about reporting requirements in the home, PSW #101 reported that it was covered in their annual training, however a time frame for reporting was not.

During an interview with Inspector #593, June 15, 2016, the Administrator reported that all staff have been instructed to report such incidents immediately to the manager on call. The Administrator confirmed that this was covered in the annual education and that it was the home's policy that all alleged incidents of abuse and neglect be reported immediately to the manager on call. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, being 21 days [log #009411-16].

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of reported resident theft. It was reported by resident #001 that valuable items had been stolen from their room.

The CI was reviewed by the CIATT team with the request to amend the CI with the outcome of the investigation. The CI was not amended until 45 days after the CI was first submitted to the Director.

During an interview with Inspector #593, June 14, 2016, the Administrator reported that they were aware that the CI needed to be updated however they had no results from their investigation as they were waiting for the Police and the resident's POA to get back to them. [s. 104. (1) 4.]

Issued on this 16th day of June, 2016

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

Original report signed by the inspector.