Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Amended Public Copy/Copie modifiée du rapport public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 05, 2021 | 2021_878551_0006 (A1) | 004134-21, 007070-21, 007237-21, 009265-21, 011370-21 | 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

Garden Terrace
100 Aird Place Kanata ON K2L 4H8

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

Amended by MEGAN MACPHAIL (551) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**A correction was made to the grounds of WN #1 with regards to resident #001.**

**Issued on this 6 th day of October, 2021 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**


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Garden Terrace
100 Aird Place Kanata ON K2L 4H8

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

Amended by MEGAN MACPHAIL (551) - (A1)

## Amended 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): August 23, 24, 25, 26, 27, 30 and 31 and September 1, 2021.**

**The following logs were inspected as part of the Critical Incident System (CIS) inspection:**

**- Log 004134-21 / CIS 2882-000006-21 was related to a significant change in a resident's health condition.**

**- Log 007070-21 / CIS 2882-000007-21 was related to the administration of medications to a resident.**

**- Log 007237-21 / CIS 2882-000008-21 was related to the fall of a resident.**

**- Log 009265-21 / CIS 2882-000011-21 was related to an allegation of theft from a resident.**

**- Log 011370-21 / CIS 2882-000013-21 was related to an allegation of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, a Housekeeper, a Screener, an Antigen Testing Staff, the Physiotherapist, the Clinical Care Coordinator, the Maintenance Manager, the Environmental Services Manager, the Infection Prevention and Control (IPAC) Practitioner, the Director of Care (DOC) and the Administrator.**

**During the course of the inspection, the inspector(s) reviewed relevant documents including residents' health care records and observed the provision of care and services to residents, dining service, housekeeping services, COVID-19 screening, antigen testing and other IPAC measures and the recording and documentation of air temperatures.**

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

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

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

**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Safe and Secure Home**

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

**4 WN(s)**
**3 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

(A1)
1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A resident required the use of a tilt wheelchair at all times for positioning.

According to the PSW who provided care to the resident, the resident was taken to their room for continence care. After continence care, the resident was left in their room seated in their wheelchair. The resident was later found on the floor and suffered an injury.

The DOC stated the chair was to be tilted to approximately a 45 degree angle. According to the CIS, “PSW reported that resident's W/C was slightly tilted at the time of the fall”.

The resident’s wheelchair was to be tilted at all times to keep them in the chair. The resident fell from their chair and sustained an injury. As such, staff did not use safe transferring and positioning devices or techniques when assisting the resident.

Sources: The resident's health care record and interviews with staff. [s. 36.]

2.

A resident's transfer status was two-person side by side and to use the mechanical lift if weak.

The resident was transferred by one person physical assistance. As such, staff did not use safe transferring and positioning devices or techniques when assisting the resident.

Sources: The resident's health care record and interviews with staff. [s. 36.]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A resident had an incidence of a fever. Three days later, isolation under contact droplet precautions was implemented, and a COVID-19 PCR swab was collected and an antigen test was conducted.

The IPAC Practitioner stated that the resident should have been isolated under contact droplet precautions immediately when they had a fever.

Sources: The resident's health care record, interview with the IPAC Practitioner and Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007. [s. 5.]

***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 to ensure that the required procedures for the management of a symptomatic resident are implemented as outlined in Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

A resident was administered medications that were not prescribed to them and were prescribed to a different resident. The resident was sent to hospital for further assessment when there was a change in their health condition.

Sources: Residents' health care records and interviews with staff. [s. 131. (1)]

***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 to ensure that no drug is administered to a resident unless the drug is prescribed for the resident, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

A PSW brought a food tray to a resident who was isolated on contact droplet precautions. The PSW was observed feeding the resident without eye protection and gloves.

The IPAC Practitioner stated that the PSW should have been wearing eye protection and gloves while feeding the resident who was on contact droplet precautions.

Sources: Observations of the inspector, interview with the IPAC Practitioner and Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007. [s. 229. (4)]

***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 to ensure that personal protective equipment is worn as outlined in Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, to be implemented voluntarily.***

**Issued on this 6 th day of October, 2021 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by MEGAN MACPHAIL (551) - (A1) |
| **Inspection No. / No de l'inspection :** | 2021_878551_0006 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 004134-21, 007070-21, 007237-21, 009265-21, 011370-21 (A1) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Oct 05, 2021(A1) |
| **Licensee / Titulaire de permis :** | 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership<br>2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6 |
| **LTC Home / Foyer de SLD :** | Garden Terrace<br>100 Aird Place, Kanata, ON, K2L-4H8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Christine Schyf |

Ontario

**Ministry of Long-Term Care**

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## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

(A1)
The licensee must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must

- Perform weekly audits to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
- Document the audits and continue auditing until consistent compliance with staff using safe transferring and positioning devices or techniques when assisting residents is achieved.
- Provide education to identified staff, and educate other staff when issues are identified, on using safe transferring and positioning devices or techniques when assisting residents.
- Document the education, including the date and name of the staff member who provided the education and the name of the staff who received the education.

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Grounds / Motifs :**

(A1)
1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A resident required the use of a tilt wheelchair at all times for positioning.

According to the PSW who provided care to the resident, the resident was taken to their room for continence care. After continence care, the resident was left in their room seated in their wheelchair. The resident was later found on the floor and suffered an injury.

The DOC stated the chair was to be tilted to approximately a 45 degree angle. According to the CIS, "PSW reported that resident's W/C was slightly tilted at the time of the fall".

The resident's wheelchair was to be tilted at all times to keep them in the chair. The resident fell from their chair and sustained an injury. As such, staff did not use safe transferring and positioning devices or techniques when assisting the resident.

Sources: The resident's health care record and interviews with staff. [s. 36.] (551)

2. A resident's transfer status was two-person side by side and to use the mechanical lift if weak.

The resident was transferred by one person physical assistance. As such, staff did not use safe transferring and positioning devices or techniques when assisting the resident.

Sources: The resident's health care record and interviews with staff. [s. 36.]

(551)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 26, 2021

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON  M7A 1N3
Télécopieur : 416-327-7603

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 6 th day of October, 2021 (A1)**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Amended by MEGAN MACPHAIL (551) - (A1)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Service Area Office / Bureau régional de services :** Ottawa Service Area Office