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 8, 2019	2019_717531_0030	009816-19, 011003-19	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

Kentwood Park
2 Ontario Street PICTON ON K0K 2T0

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

SUSAN DONNAN (531)

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): September 25, 26, 30, October 1 and 2, 2019

the following intakes were inspected;
Log #009816-19 Critical Incident #0893-000007-19 related to continence care
Log #011003-19 Critical Incident #0893-000008-19 alleged abuse

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care (DOC), the Life Enrichment Coordinator (LEC), the Nutrition Manager (NM), Registered Nurses (RN), Registered Practical Nurse (RPN),
Personal Support Workers (PSW), the Dietary staff (DS), resident Substitute Decision Makers and residents.
During the course of the inspection the inspector, reviewed resident health care records, observed resident care and services, reviewed nutrition care and services and abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse had occurred or may occur, immediately report the suspicion and information which it is based to the Director.

An inspection was conducted in relation to Intake Log #011003-19, Critical Incident System report (CIS) #0893-000008-19 which was submitted to the Director on a specified date. The Critical Incident report read that during the evening meal, Dietary Staff #106 referred to resident #001 with inappropriate comments in the dining room while serving the evening meal.

On October 2, 2019 at 1300 during an interview with Dietary Staff #104, and review of their witness statement for a specified date, they told the inspector that they told Dietary Staff #106 to cease with the inappropriate comments. Dietary Staff #104, told the inspector that they continued to serve residents and did not immediately report the incident to the nurse in charge. Dietary Staff #104 told the inspector that the incident occurred during the evening meal approximately two weeks prior to completion of the witness statement, fifteen days later. There were no untoward effects to the resident.

During an interview with the Nutrition Manager they indicated that they were not notified of the incident until a specified date at which time they initiated an immediate investigation and notified the DOC.

During an interview with the DOC and review of the internal investigation documentation the DOC told inspector #531 that the Director was notified on a specified date, fifteen days after the incident . [s. 24. (1)]

The licensee failed to ensure that the person who had reasonable grounds immediately report the suspicion and information which it is based to the Director.

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 person who has reasonable grounds that abuse has or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person hired as a nutrition manager must be an active member of the Canadian Society of Nutrition Management or a registered dietitian.

On October 2, 2019, during an interview with the designated Nutrition Manager, the Nutrition Manager told the inspector that they were not an active member of the Canadian Society of Nutrition Management. The Nutrition Manager further indicated that there is no on site Nutrition Manager to provide for the minimal 14.4 hours for the nutrition care and services program that is an active member.

During an interview with the Acting Administrator they indicated that there is a corporate Nutrition Manager, however there is no on site lead that is an active member of the Canadian Society of Nutrition Management, to provide the minimal 14.4 hour requirement.

The licensee failed to ensure the designated lead was an active member of the Canadian Society of Nutrition Management. [s. 75. (2)]

Issued on this 8th day of October, 2019

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

Original report signed by the inspector.