Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 21, 2022	
Inspection Number: 2022-1002-0001	
Inspection Type: Critical Incident System	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Kentwood Park, Picton	
Lead Inspector Anna Earle (740789)	**Inspector Digital Signature** Anna M Earle Digitally signed by Anna M Earle Date: 2022.11.30 13:28:27 -05'00'
Additional Inspector(s) Amber Lam (541)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 3,4,7,8, 2022

The following intake(s) were inspected:

- Intake: #00001831- [CI: 0893-000005-22] Staff to resident abuse.
- Intake: #00010964- [CI: 0893-000012-22] Fall of resident resulting in transfer to hospital.

The following intakes were completed in the Critical Incident System Inspection: Intake #00001680, CIS#0893-000007-22, and Intake #00005793, CIS#0893-000009-22 were related to a fall of a resident resulting in transfer to hospital.

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

Prevention of Abuse and Neglect
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

On November 3, 2022, inspector noted resident to be sitting in their wheelchair, their clip alarm was not applied and could not be seen anywhere on the resident's chair. Inspector spoke with Registered Nurse (RN) who confirmed the resident was to have a clip alarm attached while in their chair. RN accompanied inspector to resident's chair and was able to find the clip alarm in a bag behind the resident's wheelchair. The clip alarm was then immediately applied.

Sources: Resident's plan of care, interview with RN and observations of resident.

Date Remedy Implemented: November 3, 2022

[541]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

Non-compliance with: O. Reg 246/22, s. 102 (2) (b)
The licensee has failed to ensure that a standard issued by the Director with respect to point-of-care signage indicating that enhanced IPAC control measures are in place was complied with. In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the Licensee shall ensure Routine Practices and Additional Precautions

are followed in the IPAC program including point-of-care signage indicating that enhanced IPAC control measures are in place and are followed within the home.

Rationale and Summary

On November 3, 2022, at 1000 hours, inspector entered the home and was informed by Director of Care (DOC) that resident was placed on precautions at 0800 hours. Inspector noted there was no signage posted outside of resident's room indicating contact/droplet precautions were to be used. Inspector asked Registered Practical Nurse (RPN) about the missing signage, they stated that they were aware that signage was supposed to be posted, however did not have time to post sign as they were orientating a new staff member and it was a busy morning. Two hours later at 1200 hours, inspector noted the correct signage was posted outside of resident's room indicating contact/droplet precautions to be used prior to entering resident's room. No staff were observed entering resident's room without Personal Protective Equipment on and were aware of contact/droplet precautions in place for resident despite no signage.

Sources: Observation of resident room entry way and interview with RPN

Date Remedy Implemented: November 3, 2022

[740789]

WRITTEN NOTIFICATION: Restraining by physical devices

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (1)

The licensee has failed to ensure that resident's use of a tilt wheelchair as a restraint was included in their plan of care.

Rationale and Summary
At the time of inspection, resident was observed to be in a in a tilt wheelchair. According to interviews with Registered Nurse (RN) and the Director of Care (DOC), the purpose of the tilt wheelchair was for safety as it prevents the resident from climbing out of their chair. Personal Support Worker (PSW), RN, and the DOC, all stated that the resident would not be able to get out of the tilt wheelchair themselves.

Inspector reviewed resident’s health-care record including progress notes, physiotherapy assessments,

care plan and post-fall assessments and there was no documentation to indicate that the resident was using a tilt wheelchair nor that it was a restraint.

Sources: Resident's health care record, observations of resident, and interviews with PSW, RN and the DOC.

[541]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE OF ABUSE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)
The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
On May 13, 2022, resident wrote a letter with assistance from Social Worker (SW) regarding suspected abuse from staff. The letter was submitted, by email, to the Administrator on June 13, 2022. Licensee's policy: Zero Tolerance of Abuse and Neglect of Residents, policy # OP-AM-6.9, Reviewed March 30, 2022, directs any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated to immediately report the suspicion and the information upon which the suspicion is based to the Director, Homes Administrator, or manager on call.

During an interview with the Administrator, they acknowledged the letter received from Social Worker on behalf of resident on June 13, 2022, was considered a potential abuse incident by the licensee and Social Worker did not comply with the licensee's policy.

Not immediately reporting resident abuse may result in a negative outcome to the resident.

Sources: Interview with Administrator, Zero Tolerance of Abuse and Neglect of Residents Policy- Last Reviewed/Updated: March 30, 2022.

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