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
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Original Public Report

Report Issue Date: October 16, 2023	
Inspection Number: 2023-1002-0003	
Inspection Type: Critical Incident	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Kentwood Park, Picton	
Lead Inspector Kayla Debois (740792)	**Inspector Digital Signature** Kayla L Debois Digitally signed by Kayla L Debois Date: 2023.10.16 15:32:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10-12, 2023

The following intake(s) were inspected:

- Intake: #00090283 [CI: 0893-000009-23] - Alleged staff to resident neglect.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with their written policy related to zero tolerance of abuse and neglect of residents.

Rationale and Summary:
On a day in June 2023, an alleged incident of staff to resident neglect occurred between a PSW staff member and a resident. This was reported to the charge nurse by another staff member on the same day. The Administrator was informed of this incident the next day. The Director was informed of the incident on this day, when the Administrator was made aware.

The Inspector reviewed the licensee's policy Zero Tolerance of Abuse and Neglect of Residents, reviewed July 20, 2023. On page 3 of 6, the policy outlined the procedure that staff members follow when receiving a report of or observing anyone abusing or neglecting a resident in any manner. This included immediately reporting the suspicion to the Director, the home's administrator or the manager on call if any person had reasonable grounds to suspect that a resident had been neglected.

In an interview with the Administrator, they acknowledged that the charge nurse was not following their policy because they did not report the incident to them right away.

Failure to report suspected neglect as directed in the Licensee's policy can increase the risk of harm/injury to the resident.

Sources:
Licensee's Zero Tolerance of Abuse and Neglect of Residents, reviewed July 20, 2023 policy, interview with Administrator.

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WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors which led to the non-residential areas of the home were kept closed and locked when they were not being supervised by staff.

Rationale and Summary:

On a day in October 2023, Inspector observed a door to the boiler room located in the hallway of a resident home area, that was unlocked. The room was left unattended and unsupervised, and led to a non-residential area. Staff could not be found within the immediate vicinity of the room. The Inspector immediately brought the unlocked door to the attention of a Registered Nurse (RN), and they locked the door.

During an interview with the RN, it was confirmed that the door should be locked at all times.

By not ensuring that all doors leading to non-residential areas of the home were kept closed and locked, unsupervised residents may have had an opportunity to wander into the non-resident area, posing risk of injury or entrapment.

Sources:
Inspector's observation on a day in October 2023, interview with RN.

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