Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 8, 2010	2010_103_893_08Sep125013	Other (Critical Incident #0893-000006-10) Log # O-000478

Licensee/Titulaire

Omni Health Care Limited Partnership on behalf of 0760444, B.C. Ltd. As General Partner
1840 Lansdowne St. West, Unit 12, Peterborough, Ontario, K9K 2M9 Fax# 705-742-9197

Long-Term Care Home/Foyer de soins de longue durée
Kentwood Park, 2 Ontario Street, Picton, ON K0K 2T0 Fax# 613-476-3986

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

Darlene Murphy (ID#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical incident inspection related to resident rights.

During the course of the inspection, the inspector spoke with 3 residents, 2 Personal Support Workers and the Administrator.

During the course of the inspection, the inspector did a review of the resident health record and observed resident care.

The following Inspection Protocol was used during this inspection:
Dignity, Choice and Privacy Inspection Protocol.

☐ There are no findings of Non-Compliance as a result of this inspection.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.3 (1)Every Licensee of a long term care home shall ensure that the following rights of residents are fully respected and promoted: 19. Every resident has the right to have his or her lifestyle and choices respected.
Findings: 1. On July 17, 2010, upon the direct order of the Registered Nurse, a resident was forced by two Personal support workers (PSW's) to get out of bed despite the resident's refusal to do so. The PSW's attempted to inform the Registered Nurse of the plan set out in the resident's plan of care and her preferred care needs. The resident became agitated and aggressive with the staff members as a result.

Inspector ID #:	103

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6 (7)The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
Findings: 1. The resident plan of care indicates staff should "leave and return if resident refuses care", "allow flexibility with her activities of daily living to accommodate mood changes" and "staff must reapproach and provide encouragement several times for all care and meals". On July 17, 2010, the progress notes indicate the resident was approached at 0800 and 1030 but declined to get up and be dressed at that time. Despite the resident refusal, the Registered Nurse insisted the Personal support workers get her out of bed and did not follow the strategies outlined in her plan of care.

Inspector ID #:	103

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Dec 6/10 Darlene Murphy (ID #103)
Title: Date:	Date of Report: (if different from date(s) of inspection).