Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Dec 5, 2018	2018_520622_0030	026532-17	Complaint

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

Forest Hill
6501 Campeau Drive KANATA ON K2K 3E9

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

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 19, 20, 27, 28, 29, 30, 2018, December 3, 4, 2018

Complaint Intake Log # 026532-17 related to resident care and services

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Environmental/Maintenance Manager (ESM), the Resident Services Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Laundry Aide, residents and family.

During the course of the inspection, the inspector reviewed the complaint intake, the licensee's applicable complaint follow up documentation, health records, the Licensee's policies and procedures specific to Complaints Procedure #AM-6.1, Resident /Family Concerns –Laundry # ENV-LS-2.10, Procedure for Care/Cleaning of Wheelchair/Geri Chairs #CS-18.4, Enteral Tube Feeding Administration # CS-12.30 and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During an observation on November 20, 2018, inspector #622 observed specified equipment used for resident #001 to have dried on spatters of a creamy white substance.

A review of the current care plan dated a specified date indicated that the specified equipment used for resident #001 were to be cleaned nightly.

During an interview with inspector #622 on November 20, 2018, the Director of Care #101 reviewed resident #001's care plan which indicated resident #001's specified equipment were to be cleaned nightly. Inspector #622 along with DOC #101 observed resident #001's specified equipment to be soiled. DOC #101 stated that resident #001's specified equipment did not appear as though it was cleaned the previous night according to the care plan. [s. 6. (7)]

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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #001's specified equipment were kept clean and sanitary.

During an interview with inspector #622 on a specified date the Substitute Decision Maker (SDM) said they had concerns with the operation of specified equipment for resident #001. The SDM stated that staff had used specified equipment that were not clean. Staff were to monitor the specified equipment however the SDM said they had to clean the specified equipment themselves.

During an observation on November 20, 2018, inspector #622 observed specified equipment used for resident #001 to have dried on spatters of a creamy white substance. The soiled equipment was shown to DOC #101 on November 20, 2018.

During an interview with inspector #622 on November 20, 2018, DOC #101 stated that the specified equipment used for resident #001 were not kept clean and sanitary. [s. 15. (2) (a)]

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 ensure that, (a) the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

A review of the complaint letter received by the licensee dated on a specified date indicated there were concerns related to resident #001's specified care. The letter of reply written by the Administrator to the substitute decision maker (SDM) and copied to the Ministry of Health and Long-Term Care was dated a specified date, two days after the initial receipt of the complaint letter and date stamped received by the Ministry of Health and Long-Term Care nine days after the date of receipt of the initial complaint letter.

A review of the complaint letter received by the licensee dated a specified date indicated that resident 001's SDM had concern related to an incident during resident #001's specified care. The licensee's letter of reply written by the Administrator to the SDM copied to the Ministry of Health and Long-Term Care was dated a specified date, three days after the initial date of receipt of the complaint letter. The date stamp by the Ministry of Health and Long-Term Care indicated that the complaint documentation was received on a specified date, twelve days after the date of receipt of the initial complaint letter.

During an interview with inspector #622 on November 27, 2018, the Administrator said that they forwarded the complaint documentation related to resident #001 to the Ministry of Health and Long-Term Care by mail on the following dates:

- the complaint letter related to resident #001 dated a specified date, the documentation was forwarded to the Ministry of Health and Long-Term Care on a specified date two days after the date of receipt of the complaint letter.

- the complaint letter related to resident #001 dated a specified date, the documentation was forwarded to the Ministry of Health and Long-Term Care three days after the date of receipt of the initial complaint letter.

Furthermore, the Administrator stated that they should have forwarded the complaint documentation to the Ministry of Health and Long-Term Care immediately. [s. 22. (1)]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.