



**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

Direction de l'amélioration de la performance et de la
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<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection August 19, 2010	Inspection No/ d'inspection 2010_133_2834_19Aug105127 Type of Inspection/Genre d'inspection Other - Critical Incident Log # 0-000047

Licensee/Titulaire

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

Long-Term Care Home/Foyer de soins de longue durée

Forest Hill
6501 Campeau Drive
Kanata, Ontario
K2K 3E9

Name of Inspector(s)/Nom de l'inspecteur(s)
Jessica Lapensee (ID#133)

Inspection Summary/Sommaire d'inspection



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The purpose of this inspection was to conduct a Critical Incident inspection (CI # 2834-000014-10). The Critical Incident was related to a resident's fall from a tub chair lift.

During the course of the inspection, the inspector spoke with the Administrator and the Assistant Director of Care.

During the course of the inspection, the inspector reviewed the Home's two-person lifts and two-person transfers policy and the daily lift safety checklist for the tub chair lift involved in the incident. The inspector went into a tub room with the Administrator and the Assistant Director of Care and was shown how they believe the tub chair lift became unstable.

Following the inspection, copies of the ARJOHUNTLEIGH inspection of the lift involved in the incident and of the Home's inspections of the lift in June and July were faxed to the inspector.

The following Inspection Protocol was used during this inspection:
Safe and Secure Home

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

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Référant envoyé

CO – Compliance Order/Ordre de conformité

WAO – Work and Activity Order/Ordre: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10, s. 8 (1)

Where the Act or this Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure the plan, policy, protocol, procedure, strategy or system,

- (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
- (b) is complied with.



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Findings:

- 1) The licensee was found not to comply with it's policy entitled "two-person lift and two-person transfer policy" (#2.2 in the Lift Education Manual) which indicates that two employees must be present when a resident is lifted out of a tub and until the resident is safely in his or her wheelchair, chair or bed.
- 2) The Personal Support Worker that was involved in this critical incident on July 3rd, 2010 was alone when lifting the resident out of the tub.

Inspector ID #:	133
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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.

Title: _____ Date: _____ Date of Report: (if different from date(s) of inspection).

Jessica Lopensée
October 13, 2010