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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 31, 2016	2016_346133_0023	007538-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

ALMONTE COUNTRY HAVEN
333 COUNTRY STREET P.O. BOX 250 ALMONTE ON K0A 1A0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 25th and 26th, 2016

This Critical Incident System inspection was related to a Critical Incident Report submitted to the MOHLTC by the home's Administrator, with regards to a power outage that occurred on March 1st, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Maintenance worker, and a resident.

The Inspector reviewed and verified information within the submitted Critical Incident Report. The Inspector reviewed the home's emergency procedures specifically related to evacuation and reviewed the home's written emergency plans.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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 O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. O. Reg. 79/10, s. 230 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 230 (2) in that the licensee had failed to ensure that all of the emergency plans are in writing.

As per O. Reg. 79/10, s. 230 (4) 1. viii., the licensee shall ensure that the emergency plans provide for loss of one or more essential services.

As per O. Reg. 79/10, s. 19 (c), essential services include the resident-staff communication and response system.

On March 1, 2016, the home experienced a power outage. As a result, essential services, such as the resident-staff communication and response system (the system), were lost. The power outage lasted for approximately six and a half hours. As per the Critical Incident Report submitted to the MOHLTC in response to the power outage, and as per discussion with the home's Administrator on May 25th and 26th, 2016, with respect to the loss of the system during the power outage, staff were formally assigned to walk up and down the hallways. Staff continuously checked in each room for any resident that may have required assistance. Provisions were made to deal with the loss of the system.

On May 25th and 26th, 2016, the Inspector reviewed the home's written emergency plans within the navy blue "Emergency Preparedness" binder, as provided by the Director of Care, and within the red "Fire and Evacuation" binder, as located within the emergency supplies bin in the medication room. There was no written emergency plan that provided for the loss of the resident-staff communication and response system [s. 230. (2)]

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Issued on this 31st day of May, 2016

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

Original report signed by the inspector.