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
Dec 20, 21, 2016	2016_548592_0029	013405-16	Resident Quality Inspection

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. BOX250 ALMONTE ON K0A 1A0

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

MELANIE SARRAZIN (592), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 24, 25, 28, 29, 30 and December 01, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), RAI MDS Coordinator, Life Enrichment Coordinator, Nutritional Care Manager, Registered Dietitian, a Hairdresser, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a member of Family Council, Family Members and Residents.

In addition, the Inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, staff work routines, observed resident rooms, observed resident common areas, reviewed Residents' Council minutes, observed a medication pass, infection prevention and control practices and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care set out clear directions to staff who provide direct care to resident #001.

Resident #001 was admitted in 2012 with several diagnoses.

A review of resident #001's health care record was completed by Inspector #592.
The resident was identified as having altered skin integrity to a specific area. At the time of the inspection, Inspector #592 was unable to determine the date the wound commenced.
The most recent wound assessment report dated on a specific date in November 2016 indicates that the pressure ulcer was identified with a specific stage and was described with granulation tissue with specific lengths and diameters.
The Treatment Administration Report dated on a specific date in October 2016 indicated to clean the area with normal saline and to cover the wound with a specific dressing.

Inspector #592 observed RPN #109 change resident #001's dressing on November 30th, 2016.
It was noted by the Inspector and the RPN that the area identified with altered skin integrity had no dressing in place. Furthermore, the area was observed with dry areas however, no skin breakdown was observed. RPN #109 indicated to Inspector #592 that she was not sure why the dressing was not in place and left the resident's room for clarification. Inspector #592 spoke with PSW#108 who is the main care provider for resident #001. PSW #108 indicated to Inspector #592 that resident #001 has chronic issues with altered skin integrity and that he/she needed a dressing to a specific area which was provided by the registered staff. She further indicated that she has to ensure that the dressing is kept in place and intact and showed the dressing located in a different area of the body.

Several minutes after, RPN #109 entered the room and observed with the presence of the inspector the dressing on resident's #001 located by the PSW. She indicated to Inspector #592 that she would do the treatment as prescribed in the Treatment Administration Report and would report to her manager for clarification as she was unsure where the treatment was required.

On November 30, 2016, in an interview with RPN #115, she indicated to Inspector #592 that resident #001 has a past history of pressure ulcers. She further indicated to

Inspector #592 that resident had two pressure ulcers in the past which was healed and that only one pressure ulcer was remaining which was the same area identified by RPN #109.

On December 01, 2016, upon reviewing resident's #001 health care records with the presence of Inspector #592, the DOC was unable to explain to the Inspector which part of the resident's body was requiring treatments. She further indicated to Inspector #592 that the plan of care was unclear and that she would have to do a follow-up with the Clinical Care Manager to ensure that resident #001 is receiving appropriate care with clear directions.

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 to ensure that the plan of care for resident #001 will set out clear directions to staff who provide skin care to resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with section 9(1)2. of the regulation in that the licensee failed to ensure all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Inspector #138 toured the home on November 24, 2016, and noted that the door to the laundry room and the door to the mop room, both located in the service corridor, were closed but unlocked. The Inspector entered both rooms and noted that they were unattended. It was also noted by the Inspector that there was no staff present to supervise either of these doors. The Inspector continued to tour the rest of the home and observed that the doors to the three linen rooms, one on each residential corridor, did not have a lock and could be opened. This made the linen rooms accessible. On A corridor, it was observed that the door to the utility room had a key in the lock which allowed for the door to be opened and the room accessible. On B corridor, it was also observed that the door to the equipment storage room had a key in the lock which allowed for the door to be opened and the room accessible. It was noted that the laundry room, mop room, linen rooms, the equipment storage room, and the utility room were not equipped with a resident-staff communication and response system (commonly known as the call bell system).

During the lunch meal service on November 28, 2016, the Inspector observed the door to the hairdressing room to be unlocked and unattended. The Inspector later spoke with the hairdresser and she stated that the door is usually locked but when the door is unlocked the room is supervised by the home's staff. It was noted by the Inspector, however, at the time of the observation that there was no staff in the area to supervise the room. It was also noted by the Inspector that there was no call bell in the hairdressing room.

Also during the lunch meal service on November 28, 2016, the Inspector observed the door to the equipment storage room on B corridor to be propped open with a four liter bottle of CS20, a corrosive high level disinfectant which is considered a hazardous product. There was no staff in the area. The Inspector monitored the opened door from 1237 hours to 1250 hours and noted that there was no staff supervision of the room during this time. At 1250 hours, the Inspector removed the bottle of CS20 and closed and locked the equipment storage door.

The Inspector spoke with the Administrator on November 30, 2016, regarding the above unlocked doors. The Administrator agreed that, with the exception of the hairdressing room, the unlocked doors noted above lead to non residential areas and that she would take actions to ensure these doors are kept closed and locked when not supervised by staff. [s. 9. (1) 2.]

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 to ensure doors leading to non residential rooms containing unsecured hazardous products are keep closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 was admitted in 2012 with several diagnoses.

A review of resident #001's current plan of care was completed by Inspector #592.
The resident was identified as having altered skin integrity to a specific area. At the time of the inspection, Inspector #592 was unable to determine the date the wound commenced.
The most recent wound assessment report dated on a specific date in November 2016 indicates that the pressure ulcer was identified with a specific stage and was described with granulation tissue with specific length lengths and diameters.
The Treatment Administration Report dated on a specific date in October 2016 indicated to clean the area with normal saline and to cover with a specific dressing.

On November 30, 2016, in an interview with RPN #109, she indicated to Inspector #592 that resident #001 was still exhibiting altered skin integrity and was requiring treatments. She further told Inspector #592 that a weekly skin assessment was performed for each resident exhibiting altered skin integrity including resident #001 using the wound tracker located in their electronic software. She further indicated to Inspector #592 that a picture of the wound was also taken as part of the skin assessment.

In a review of the resident's health care records, Inspector #592 was unable to find any skin assessment performed for resident #001 for November 12, 19 and 26, 2016.

On December 01, 2016, the DOC indicated to Inspector #592 that a weekly wound assessment should be completed for each resident exhibiting altered skin integrity until the area has healed including resident #001 who continues to have altered skin integrity. Upon reviewing resident's #001 health care records in the presence of Inspector #592, the DOC indicated to the Inspector that the last skin assessment done for resident #001 was dated over three weeks earlier . She further indicated to Inspector #592 that resident #001 should have had a weekly wound assessment completed as part of the home's wound care program.

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 to ensure that resident #001 exhibiting altered skin integrity will be reassessed at least weekly by a member of the registered staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 33.(3) of the Act in that the licensee failed to ensure that a personal assistive service device (PASD) is included in the plan of care.

According to section 33. (1), (2) and (3) of the Act a PASD is a device used to assist a person with a routine activity of living. A PASD that has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themselves from the PASD must be included in the resident's plan of care.

The following are two instances in which a device, determined to be a PASD, was used with a resident without being included in the residents plan of care (as defined by the home).

1) Inspector #138 observed resident #018 on November 28 and 29, 2016, in bed sleeping with one full bed rail in the up position. The Inspector further observed throughout the course of the inspection that the resident was independent with mobility including getting in and out of bed on the side without a bed rail. PSWs reported to the

Inspector that the resident would not be able to release the bed rail if the resident wanted to.

The Inspector reviewed resident #018's plan of care which stated that bed rails are to be used as ordered however the plan of care did not provided specific instructions on whether a bed rail was used. The Inspector further reviewed the resident's health care record and could not locate any written instruction nor any consent for the use of the bed rail.

On November 29, 2016, the Inspector spoke with RPN #110 regarding the use of bed rails in the home. The RPN confirmed that the use of bed rails for a resident would require an assessed, consent, and inclusion in the plan of care. The Inspector further spoke with the RPN specifically regarding the use of the bed rail for resident #018. The RPN was unable to determine why the resident was using one full bed rail. The RPN discussed the use of a bed rail for resident #018 with the Administrator who then conducted an investigation. The Administrator reported to the Inspector that the resident was not supposed to be using the bed rail at this time, however, staff had reported to her that they had put the bed rail up at the resident's request for positioning assistance. The Administrator stated that if the resident wishes to continue to use the bed rail then the home would initiate the appropriate process for bed rail use which includes updating the plan of care.

2) Inspector #592 observed resident #001 on November 28, 2016, seated in a wheelchair with a front closure lap belt applied. Inspector #138 then observed the resident on November 29, 2016, seated in a wheelchair, however, no lap belt was applied at this time. The Inspector spoke with PSW #107 on November 29, 2016, regarding the use of a lap belt for resident #001. The PSW stated that the resident's lap belt was included as part of the resident's wheelchair but that the lap belt is not to be applied as it is not part of the plan of care nor has there been consent for its use.

Inspector #138 observed the resident again throughout the morning of November 30, 2016. It was noted that the resident was seated in a wheelchair, this time, with the lap belt applied. The Inspector spoke with the resident that morning and observed that the resident was not cognitively capable of releasing the lap belt. The Inspector then spoke with another PSW, PSW #108, who stated that the lap belt would be applied for this resident for safety reasons.

Inspector #138 reviewed the resident's plan of care and was unable to find any indication

that the resident was to wear a lap belt while seated in a wheelchair. The Inspector further reviewed the resident’s health care record and was unable to find any documentation that supported the use of the lap belt. The Inspector reviewed this with both the Director of Care and the Administrator, who indicated that they would resolve the situation. [s. 33. (3)]

Issued on this 21st day of December, 2016

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

Original report signed by the inspector.