Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_582548_0020	023010-17	Complaint

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

RUZICA SUBOTIC-HOWELL (548)

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): October 18,19 and 25, 2017

The inspector reviewed resident health care records, staff schedules and staffing complement, critical incident reports, home's policies on the Prevention of Falls and Neurological Assessment Post Head Injury, Shift reports, email correspondence from the Substitute decision-makers to the Administrator and Director of Care, letter correspondence from the Administrator to the Substitute decision-makers, letter correspondence from a Personal Support Worker to the Administrator and email correspondence from the Substitute decision-maker to the Inspector.

During the course of the inspection, the inspector(s) spoke with the Substitute decision-maker, Administrator, Director of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Office Manager and Scheduling Coordinator.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 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. (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 failed to ensure that the care set out in the plan of care is provided to the resident #001 as specified in the plan.

The resident's #001 substitute decision-maker contacted the Director with concerns related to the care being provided to the resident. A Critical Incident Report was submitted related to an incident that caused an injury to the resident for which the resident #001 was taken to hospital and, there was significant change in the resident's health status due to a sustained injury. The resident subsequently died while hospitalized.

The resident #001 had a history of falls and was known to be at risk for falls. The resident 's #001 current care plan specified Fall Prevention and Toileting interventions were to be implemented due to the resident's comorbidities and, physical and cognitive limitations.The resident was to be assisted for all toileting needs. Both the Fall Prevention and Toileting interventions specified that the resident was to have a staff member present.

In the two Minimum Data Set conducted in 2017 indicated that resident's #001 cognitive ability for daily decisions was modified and the resident could misinterpret messages conveyed to the resident. As well, the daily use of antidepressants placed the resident at risk for falls.

On October 19, 2017 during an interview with Inspector #548 PSW #100 indicated that she has been employed at the home fulltime and knew the resident. She indicated that she has access to all the resident's care plans however, was not aware of the care plan interventions specified that a staff member must remain with the resident #001 while being toileted. She indicated at that time of the incident that she and another PSW# 107 pivot transferred the resident between surfaces to the toilet. She explained that she wanted to provide the resident privacy and provided the resident with the call bell with instructions on how to use it. She further indicated that she partially closed the door and left the room to retrieve supplies. While in the hallway, she indicated that she heard the call bell. The resident had sustained an unwitnessed fall and was found on the floor laying on the right side. She indicated that she manages her time and she multitasks to complete the necessary work.

During an interview with RN #104 she indicated that she worked at the time of the incident. She indicated that post incident the resident was transferred to bed, assessed and provided medication for voiced minimal discomfort. She indicated that she recalls there were no changes to the resident's #001 care that needed to be communicated to the PSWs as this would have been conveyed to them at shift change. She indicated that the usual practice at the home is if any resident mobilizes with a wheelchair that they are

not to be left alone during toileting.

During interviews with RPN #102 and RPN #103 both indicated that the resident #001 was known to have altered states of cognition and to meet resident needs the resident was not to be left unattended while toileted. Both indicated that changes to the plan of care are reviewed with PSWs.

A letter dated four days post incident was directed to the Administrator from PSW #100. She indicated in the letter that when resident #001 indicated the need for bowel elimination she informed the resident that she would provide the resident with privacy and proceeded to partially close the bathroom door; she indicated that she was able to visually see the resident. She further explains, in an effort to manage time she will multitask and she left the room for supplies and returned to the room upon hearing the call bell. The resident #001 was found on the floor.

From the interview and letter PSW #100 was unable to substantiate the amount of time the resident was left unattended.

The resident #001 resided in a private room with a private bathroom. The bathroom is to the left of the bed and when standing at the threshold of the room the inside of the bathroom is not visible as the door opens towards the entrance. The inspector partially opened the door in the presence of PSW #100 who indicated that the opening was at the approximately the same place as the night of the incident. There is no visibility into the bathroom standing adjacent to the door and from the threshold of the door opening into the room.

Staff did not ensure that the care set out in the plan of care was provided to the resident #001 as specified in the plan.

A compliance order is warranted as resident’s #001 had a significant change in health status as a result of the fall incident and, this is the second reported incident involving the resident being left unattended and sustaining an unwitnessed fall. The non-compliance presents actual harm to the resident and a compliance order will be served to the Licensee. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 20th day of November, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : RUZICA SUBOTIC-HOWELL (548)

Inspection No. / No de l'inspection : 2017_582548_0020

Log No. / No de registre : 023010-17

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Nov 17, 2017

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

LTC Home / Foyer de SLD : ALMONTE COUNTRY HAVEN
333 COUNTRY STREET, P.O. BOX250, ALMONTE, ON, K0A-1A0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Carolyn Della-Foresta

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To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall:
1. review and revise the plan of care of all residents requiring assistance and/or supervision with toileting to ensure the care needs of each resident and the required interventions to address those needs are clearly identified;

2. implement a monitoring process to ensure staff providing assistance and/or supervision with toileting do so in accordance with the resident's plan of care; and

3. provide immediate re-instruction to staff who fail to provide residents with the assistance and/or supervision required to meet each resident's toileting needs with toileting in accordance with the plan of care.

Grounds / Motifs :

1. 1. The Licensee failed to ensure that the care set out in the plan of care is provided to the resident #001 as specified in the plan.

The resident's #001 substitute decision-maker contacted the Director with concerns related to the care being provided to the resident. A Critical Incident Report was submitted related to an incident that caused an injury to the resident for which the resident #001 was taken to hospital and, there was significant change in the resident's health status due to a sustained injury. The resident subsequently died while hospitalized.

The resident #001 had a history of falls and was known to be at risk for falls. The resident's #001 current care plan specified Fall Prevention and Toileting interventions were to be implemented due to the resident's comorbidities and,

physical and cognitive limitations.The resident was to be assisted for all toileting needs. Both the Fall Prevention and Toileting interventions specified that the resident was to have a staff member present.

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A compliance order is warranted as resident's #001 had a significant change in health status as a result of the fall incident and, this is the second reported incident involving the resident being left unattended and sustaining an unwitnessed fall. The non-compliance presents actual harm to the resident and a compliance order will be served to the Licensee. [s. 6. (7)] (548)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of November, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Ruzica Subotic-Howell

Service Area Office / Bureau régional de services : Ottawa Service Area Office