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

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

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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
Nov 22, 2018	2018_593573_0016	002849-18, 008573-18	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

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

ANANDRAJ NATARAJAN (573)

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 16, 17, 18, 22 and 23, 2018.

The following intakes were inspected during this inspection:
Log #002849-18 (complaint regarding resident care and services) and Log #008573-18 (refusal of application for admission)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Services Coordinator (RSC), Community Care Access Centre, Client Services Placement Coordinator, Registered Nurse (RN), Registered Physiotherapist (PT), Registered Dietitian (RD), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Substitute decision-maker (SDM).

Inspector reviewed resident health care records including care plans, assessments, progress notes, Medication/ Treatment administration records and PSW Daily Care Flow sheet documentation. Reviewed applicant's letter/ application for declined admission to the home.

In addition Inspector observed the provision of care and services to the residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Nutrition and Hydration
Personal Support Services

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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute Decision-Maker (SDM), if any, and the designate of the resident/ SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Ministry of Health and Long Term -Care (MOHLTC) regarding the care and services received by resident #001 at the LTC home.

Resident #001 health record identified that the resident had substitute decision maker (SDM) for personal care.

On October 16, 2018, Inspector #573 spoke with resident #001's SDM, who stated that they were not informed when resident's physiotherapy treatment were cancelled upon resident's refusal. The SDM stated that they were not informed by the registered nursing staff when resident #001 was assessed and prescribed new medicated creams. Further, the SDM stated that they were not notified when there was a change in resident #001's mobility status.

On October 17, 2018, Inspector #573 reviewed resident #001's progress notes for the month of a specified month in 2017.
- Progress notes on a specified date, entry by the physiotherapist, indicated that resident refused physiotherapy treatment and resident was not scheduled for physiotherapy treatments.
- Progress notes on a specified date, entry by RN #101, indicated that in home physician was notified and ordered medicated creams for resident #001.
- Progress notes on a specified date, entry by RPN #102, indicated that resident #001 was not able to ambulate and resident was provided with loaner wheelchair for mobility.

A further review of resident #001's progress notes, found no documentation that the resident's SDM was made aware of with the above identified information.

During an interview, the physiotherapist stated to Inspector #573 that resident #001's SDM was not informed regarding the physiotherapy treatments that was cancelled upon resident's refusal.

On October 17, 2018, Inspector #573 spoke with RN #101, who stated that on a specified date, physician was notified and ordered medicated creams for resident #001.

Inspector #573 reviewed resident #001's health care records in the presence of RN #101. Upon review, the RN indicated that the consent box in the physician order for the medicated creams was ticked off by a registered nursing staff. RN #101 stated to inspector that there was no information regarding who provided the consent and also no documentation that resident #001's SDM was informed the new medication order. Further, the RN stated that there was no documentation in progress notes that the resident #001's SDM was informed the change in resident's mobility status on the specified date.

The licensee has failed to ensure that resident #001's substitute decision-maker was given an opportunity to participate fully in the development and implementation of resident #001's plan of care.(Log #002849-18) [s. 6. (5)]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.