Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: July 14, 2023

Inspection Number: 2023-1192-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

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

Long Term Care Home and City: Almonte Country Haven, Almonte

Lead Inspector	**Inspector Digital Signature**
Laurie Marshall (742466)	Laurie R Marshall Digitally signed by Laurie R Marshall Date: 2023.08.04 13:26:59 -04'00'

Additional Inspector(s)
Ashley Martin (000728)
Dee Colborne (000721)
Manon Nighbor (755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 10-12, 15-19, 23, 24, 2023.

The following intake(s) were inspected:

- Intake: #00001729 - [AH: IL-05025-AH/CI: 2692-000011-22] Fall of resident resulting in significant change in condition.
- Intake: #00002535 - [AH: IL-00054-AH/CI: 2692-000002-22] Alleged verbal abuse by resident towards co-resident.
- Intake: #00006736 - [AH: IL-98541-AH/CI: 2692-000001-22] Alleged sexual abuse by resident towards co-resident.
- Intake: #00021347 - Follow-up #: 1 - O.Reg. 246/22 - s. 93 (2) (b) (iii)
- Intake: #00087324 - Complaint regarding Care and Services.

Note: A compliance order related to O.Reg. 246/22 s. 93 (2) (b) (iii), was identified in this inspection and had been issued in a previous inspection, #2023-1192-0001, issued on February 16, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #01 from Inspection #2022-1192-0001 related to O. Reg. 246/22, s. 93 (2) (b) (iii) inspected by Laurie Marshall (742466)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (a)

The Licensee has failed to ensure that there is a written plan of care that sets out the plan of care for the resident.

Rationale and Summary:
A Resident touched another resident inappropriately.

Administrator advised the touching was not substantiated but interventions were in place to keep both residents.

Upon review of the resident's plan of care, there were no interventions documented to keep the residents away from each other.

Sources: Plan of care, Interviews with staff.
[000721].

WRITTEN NOTIFICATION: Failure to report alleged sexual abuse immediately

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The Licensee failed to report alleged sexual abuse to the Director immediately.

Rationale and Summary
A resident allegedly was inappropriately touching another resident. Progress notes identify that the inappropriate touching occurred and for staff to monitor. The home did not report the incident until two days later, via the afterhours action line.

Administrator was not able to confirm the reason for reporting the incident late.

Sources- Interview with Administrator, Progress notes, Investigation Notes, After hours action line report, CI #2692-000001-22.
[000721].

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

A) The licensee failed to ensure the plan of care was updated in regards to strategies and interventions to prevent the resident from touching another resident inappropriately.

Rationale and Summary:
A resident allegedly touched another resident.

During review of the resident's progress notes, it was noted that the resident continued to want to hold

another resident's hands and remain close to them. The progress note noted that staff were trying to keep both residents away from each other.

Interview with staff confirmed they were trying to keep residents separated and monitored.

Interview with staff confirmed that the plan of care should be updated to reflect interventions put in place.

Interview with Administrator also confirmed that the plan of care should be updated at the time of concerns and gave direction to staff to do so.

Review of the plan of care noted that interventions for the residents inappropriate sexual behaviours were not implemented/documented in the plan of care.

Staff being unaware of the plan of care requirements places the residents at risk of harm.

Sources- Residents plan of care, progress notes, and interviews with staff.
[000721].

B) The home has failed to update resident #004's plan of care identifying a mobility status change following a fall that resulted in a right hip fracture.

Rationale and Summary:

Resident #004 sustained a fall that resulted in significant change. Upon return from hospital, the resident's mobility status changed from independently mobile too dependent on staff for all transfers.

In accordance with FLTCA s. 6 (10) b Plan of Care, (10) The licensee shall ensure that the resident is re-assessed, and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Specifically, the home failed to update the resident's plan of care upon return from hospital that identified the change in residents mobility status.

In the homes post fall algorithm, it states that the residents care plan is to be updated following a fall.

Failing to update the residents plan of care may increase the resident's risk of injury.

Sources: Care plan, interview with staff and the LTCH's falls program and interviews with other staff. [000728]

WRITTEN NOTIFICATION: Plan of Care -Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Rational and Summary:

A resident's plan of care indicated that they required one person assistance or total assistance for their bathing care. There was no documented record that the resident received bathing care assistance for a period of 8 days.

The same resident's plan of care stated that the resident required encouragement every morning and night to complete their mouth care and for staff to assist as needed. There was no documented record for six days, related to the resident mouth care.

A staff members indicated that the care provided was not recorded and the Director of Care confirmed that the care provided should have been documented.

Sources: Residents health care record and interviews with multiple staff members. [755]

WRITTEN NOTIFICATION: Conditions of Licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

Rationale and Summary:

The Licensee has failed to comply with the conditions of Compliance Order (CO) #001 issued February 29, 2023 under inspection report 2022-1192-0001 with a compliance order due date of March 29, 2023.

The licensee was required by CO #001 to be in compliance with O.Reg. s. 93 (2) (b) (iii). CO #001 required the home to take immediate corrective action if deviations occur from the developed housekeeping program for cleaning and disinfecting high-contact surfaces.

A Follow-up inspection was conducted on May 10-12, 15-19, 23, 24, 2023.

A memo was sent to staff, dated March 24, 2023, regarding the homes new plan to implement a unit specific high touch surface cleaning checklist. The memo also stated that if documentation was incomplete then the cleaning did not occur.

Review of the homes IPAC High Touch Surface Cleaning Checklist binder located on Kinburn Lane and Naismith Lane identified that for the month of May 2023, 31 entries were missing to confirm daily disinfecting of high touch surfaces in resident care areas.

The homes "Working Short Guidelines" on page three, indicated that housekeeping staff are to readjust cleaning routine according to immediate need.

Inspector #755 interviewed housekeeping staff who reported that in the last month there were at least two times that high touch surfaces were not done because of staffing shortages.

Interview with the Manager of Housekeeping, Maintenance and Laundry reported that high touch surfaces were not being done daily because of staffing shortages and communication with PSW's to assist was not consistently done. They also added that each shift, each department was responsible for their part of the IPAC binder for high touch surfaces.

Interview with IPAC Lead reported that prior to May 24th, 2023, they had not sent out any emails or documentation regarding corrective action for high touch surface areas. IPAC Lead reported that housekeeping issues may be related to short staffing but that is something that was addressed in morning management meetings.

Failure to implement the organized program for disinfecting high touch surfaces at least daily and take immediate corrective action if there were deviations from the developed housekeeping program specifically staffing shortages, increases the risk of disease transmission between staff and residents.

Sources: IPAC High Touch surface binder for Resident Care units; Staff Memo; Working Short Guidelines; Interview with housekeeping staff, IPAC Lead, Manager of Housekeeping, Maintenance and Laundry. [742466]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
The licensee was required by CO#001 to be in compliance with O.Reg. s. 93 (2) (b) (iii). CO #001 required the home to take immediate corrective action if deviations occur from the developed housekeeping program for cleaning and disinfecting high-contact surfaces.

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1) The licensee failed to ensure support for residents to receive hand hygiene prior to receiving meals. The licensee failed to ensure staff perform hand hygiene as required.

Rationale and Summary

During inspection, inspector #000721 observed a PSW coming out of a residents room with gloves on and carrying soiled linens. The PSW proceeded to the garbage/linen cart and disposed of soiled linens and removed their gloves in the garbage. They did not perform hand hygiene after taking their gloves

off. The PSW then proceeded into another resident room to answer the call bell and did not perform hand hygiene prior to entering the room. Inspector #00721 waited a few minutes and then observed the same PSW exit out of the resident's room with soiled linens and gloves on. They once again removed gloves and disposed of linens and did not perform hand hygiene. They then proceeded to walk down the hall and pass where inspector was standing and then went to a hand sanitizer unit and sanitized hands.

Another observation made by inspector #00721 observed staff bringing in residents to dining room for lunch. No residents were cued or offered assistance of hand hygiene of any sort upon entering dining room and being seated nor before starting to eat their meal.
Two residents in the activity room were assisted to sit there and not offered or cued for hand hygiene prior to when they were served their lunch meal.
Another resident was seated in tv lounge area and an overbed table was brought in front of them and they were not cued or offered hand hygiene when they were seated or prior to being given their meal.
Multiple residents were also seated in their seats and not cued or offered hand hygiene prior to their soup being served.

Interview with a PSW confirmed that they should have performed hand hygiene after removing gloves and prior to entering another residents room.
Interview with the IPAC lead confirmed that staff should be assisting and cueing residents to perform hand hygiene prior to residents receiving their meals.

Inspector reviewed the home's policy on hand hygiene which also clearly states that residents perform hand hygiene prior to meals with the assistance of staff.

Sources- Review of homes policy on hand hygiene, Observations, and interviews with PSW and IPAC lead.

2)The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive, the Infection prevention and Control (IPAC) Standard, the licensee was required to ensure that Additional Precautions are followed in the IPAC program, including ensuring there is a doffing area to dispose of PPE, at the point of exit, for residents on contact precautions.

Rationale and Summary:
On May 11, 2022, Inspector #000721 was conducting the initial tour of home and made note of the

rooms on contact precautions. Appropriate PPE supplies were hanging but there was no area to dispose of PPE for doffing purposes in any of the rooms. Inspector #00721 noted one garbage/linen carts placed at the end of the hallway only. A PSW confirmed there should probably be a garbage bin in the rooms. IPAC lead, confirmed there should be garbage bins placed in each room for doffing purposes.

Sources- Interviews with IPAC lead, and PSW, Observations during tour of home

3) In accordance with the Minister's Directive, the Infection prevention and Control (IPAC) Standard, the licensee was required to ensure that Routine Precautions are followed in the IPAC program, including ensuring staff wear their facial masks at all times when in a resident home area.

The licensee shall ensure that staff wear their masks at all times when in resident home areas

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive, the Infection prevention and Control (IPAC) Standard, the licensee was required to ensure that Routine Precautions are followed in the IPAC program, including ensuring staff wear their facial masks at all times when in a resident home area.

Rationale and Summary

Inspector #00721 noted that a PSW sitting down at the desk speaking to a staff member who was standing within two meters of each other and had their mask down under their chin.
PSW reported that they were aware that they should have their mask on in a resident home area.

Sources- Observations and interview with PSW.
[000721]

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