Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 15, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, Apr 2, 3, 4, 5, 2012	2012_044161_0017	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

KATHLEEN SMID (161), COLETTE ASSELIN (134) LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Life Enrichment Coordinator, Maintenance Person, Housekeeping Manager, Dietary Service Manager, a Dietary Aide, several residents and several resident family members.

During the course of the inspection, three complaint inspections were also conducted: log # O-000384-12, # O-000439-12 and # O-000519-12.

During the course of the inspection, the inspector(s) reviewed residents' health care records, observed care and services provided to residents, reviewed the Quality Improvement Policies, Restraint Policy # CS-5.1, Resident Council minutes, Family Council minutes, reviewed the home's Activity Calendar, Resident Information package, Registered Staff work schedules, examined resident main and small dining rooms, examined resident common areas including tub and shower rooms, resident rooms and bathrooms, observed resident activities, observed March 19, 2012 lunch time meal services, observed resident medication passes, observed snack and beverage passes on March 19 and 20, 2012.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee failed to comply with the LTCHA 2007 s. 6 (1) (c) in that the residents' plan of care does not give clear direction to staff and to others who provide direct care to residents.

Resident # 01's plan of care does not provide clear direction to staff in regards to the resident's personal hygiene, clothing and bathing needs. The resident is known to refuse care. He/She was observed to wear his/her outdoor coat at all times throughout this inspection. His/Her clothing was observed to be unchanged and soiled during the course of this inspection. His/Her fingernails were noted to be untrimmed and unclean. An interviewed PSW reported that the resident's toenails required cleaning and trimming and that the resident's underwear was soiled. Daily care flow sheets from December 2011 to March 2012 indicate that the resident refused his/her bath 75% of the time and that baths were not rescheduled. There are no interventions identified to direct staff when the resident refuses his/her morning care, nail care, scheduled baths and change of clothing. Also there is no direction to staff to ensure that the resident is wearing appropriate indoor/outdoor clothing. [Log # O-000384-12] (134)

Resident #501's plan of care does not provide clear direction to staff in regards to the resident's risk of falls and use of a safety device. The resident was observed to have a rear fastening lap belt restraint applied for five days in March 2012. The resident's plan of care did not provide clear direction on how to apply the restraint device when the resident is seated in his/her wheelchair and to monitor the resident's response to the use and application of the restraint. The plan of care also provides conflicting information as to the method of transfers and his/her toileting needs: 2-person manual transfer, mechanical lift transfers and weight bearing for toileting transfers. (134)

Resident # 535's plan of care does not provide clear direction to staff as to the type of mechanical lift to be used for his/her transfers, the number of staff required to assist with his/her transfers and to the resident's mobility. The resident's plan of care currently identifies that the resident is both a manual and mechanical lift transfer. Interviewed a PSW who stated that resident is transferred with a sit-stand mechanical lift. The plan also identifies the resident as mobilizing with a walker and it does not identify the resident's observed use of a self propelled wheelchair nor does it identify the observed use of a Personal Assistance Service Device lap belt for safety. (117)

Resident # 557's plan of care does not provide clear direction to staff as to the resident's toileting transfers and his/her incontinence needs. It gives conflicting information regarding his/her toileting transfer needs. It indicates that the resident is to be independent with his/her toileting but is also at risk for falls and requires 2 staff assistance. There is also conflicting information regarding the type of continence product to meet the resident needs and there is a lack of information as to the resident's scheduled toileting plan. As such, the directions to staff related to incontinence are not clear. (134)

Resident # 572 plan of care does not identify and set out clear directions to staff in regards to the removal of facial hair and maintaining the integrity of his/her lips and skin around his/her mouth. The resident repeatedly licks his/her lips and the skin around his/her mouth, causing irritation, redness and chapping. The plan of care does not identify this behaviour, nor the staff's interventions of applying Vaseline, as a skin protection. The plan of care does not identify that the resident has facial hair that requires regular trimming during his/her scheduled bath. This is validated by two interviewed PSWs. (117)

Resident # 572 is diagnosed as having dementia. He/She is followed by psychogeriatric outreach services. The resident's plan of care does not identify any of the resident's responsive behaviours for which he/she is being seen by the psychogeriatric outreach services. The plan of care does not identify any behavioural triggers, behavioural interventions and does not provide clear direction to staff related to the Resident's anxiety, repetitive tactile behaviours, resistance to care and verbal aggression as identified in the psycho-geriatric assessment in December 2011. (117)

Resident #572 was observed to have a lap tray with rear clip restraint applied when he/she is seated in his/her geri-chair for five days in March 2012. The resident's plan of care does not identify the ongoing use and application of a lap tray with rear clip restraint when he/she is seated in his/her geri-chair. Two interviewed PSWs state that the resident is to be restrained with the lap tray when the resident is seated in his/her geri-chair. (117)

Resident # 576 is identified as being at high risk for falls. The resident's plan of care does not identify the resident's ongoing use of a bed alarm monitoring system as a fall prevention intervention. The bed alarm was observed to be in

place and in use one day in March 2012. An interviewed PSW confirmed the daily use of the bed alarm when the resident is in bed. (117)

2. The licensee failed to comply with LTCH 2007 s.6. (9)(1) in that the provision of care as set out in the plan of care is not documented.

Resident # 003 was assessed by the home's registered Dietician as requiring Ensure Plus 117 ml po TID as well as High Protein Pudding to be provided at the afternoon snack. The resident's Daily Food and Fluid intakes for June and July 2011 were reviewed. There is no documentation indicating that Resident # 003 received his/her prescribed nutritional supplements 196/217 times. [Log # O-000519-12] (161)

Resident # 003 Medication Administration Records were reviewed for June and July, 2011. In June 2011, Enalapril was not signed as administered once and Mirtazapine was not signed as administered 4 times. In July 2011, Ativan was not signed as administered once and the monitoring of Oxygen Saturation levels were not documented 9 times. [Log # O-000519-12] (161)

Resident # 572 is a resident who was assessed by the home's Registered Dietician, on December 2, 2011, as requiring Ensure Plus 117 ml po TID with his/her meals. A review of the December 2011 to March 2012 food and fluid flow intake sheets indicate that the PSW staff did not consistently document the resident's dietary supplement intake on a daily basis. The Nutritional Manager and a PSW stated that they do not consistently document the resident's dietary supplement consumption or refusal. (117)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services
Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s. 15 (2) (a) (c) in that the home is not kept clean and sanitary.

On March 19, 20, 21, 2012 it was observed:

The small dining room's two, lower left cupboard doors had debris on them.

The small dining room's top and bottom cupboard shelves had debris on them and rings of dried liquids.

The small dining room's bottom right cupboard contained an electric can opener, waffle maker and kettle with debris on them.

The small dining room cupboard drawers' contained debris.

The small dining room's outside and inside of the refrigerator had debris and tacky to the touch.

The small dining room's shelf along the bottom of the window is dirty and contains debris.

The housekeeper was interviewed and she indicated that there was not a regular cleaning schedule in place for this area.

The Administrator validated that she would put a plan in place to rectify the cleaning of the small dining room.

Carts labeled Tena, Towels, Linen and Personal, located on A, B, C wings noted to have debris on them.

Mechanical lifts noted to have debris on them.

On March 19, 20, 21, 22, 2012 it was observed in the Resident lounge adjacent to the nursing station, that the loveseat cushions and two out of three chair cushions are flat, sagging and offer little support to residents.

All dining room table legs are scuffed and missing finish.

All dining room chair arms and legs are scuffed, stained and finish worn.

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 small dining room cupboards, the carts and the mechanical lifts are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with r. 90 (2) (d) to ensure that the washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

On March 22, 2012 it was observed that the tub room located in corridor B had a damaged entrance door, damaged door frame, call bell wall mount covered with plastic held by duct tape and missing/broken ceramic wall tiles.

On March 22, 2012 it was observed in multiple resident bathrooms that the counter tops were heavily stained and the finish was worn.

On March 22, 2012 it was observed in multiple resident bathrooms that on the wall adjacent to the toilet, there are rusted, pock marked metal holders.

On March 19, 20, 22, 2012 caulking around the base of several toilets in residents' bathrooms was found to be stained, discolored and in a poor state of repair.

The bathroom door is missing from an identified esident's room.

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 ensure that all equipment in the home are kept in good repair and that all plumbing and washroom fixtures, and accessories are maintained and kept of corrosion and cracks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 110 (1) (1) Reg 79/10, in that the licensee failed to apply a physical device to Resident # 501 in accordance with the manufacturer's instructions.

On March 21, 2012, Resident #501 was observed wearing a lap belt restraint which had been incorrectly applied around his/her abdomen. It was not anchored to the wheelchair and was fastened at the back of the wheelchair.

On March 27, 2012, the lap belt was observed to be applied incorrectly while the resident was in his/her wheelchair. It was looped around the right armrest and applied tightly over the resident's abdomen and was fastened at the back of the wheelchair.

The licensee's "Least Restraint, Last Resort Policy" # CS-5.1 was reviewed. There is an entry in section 9 of the policy that specifies that rear fastening belts are considered unsafe and shall not be used in the home.

On March 28, 2012, inspector #134 assessed the status of Resident # 501's new restraint application. The Resident was sitting quietly in his/her chair with his/her new restraint on. The resident's restraint was twisted and applied tightly over his/her lower abdomen. The 2 PSWs, assigned to his/her care, reported that they were directed by the RN to check on the resident every 15 minutes but not informed of what to monitor. The 2 PSWs were not aware of the full operation of the new restraint and the correct application as per the manufacturer's instructions.

On March 30, 2012, two PSWs, assigned to his/her care reported to inspector # 134 that they were not told at morning report about Resident #501's new restraint and they reported that they were not aware that the belt required 12 lb strength to release it. One PSW reported she was informed to check on the resident every 15 minutes but was not aware of what she needed to observe.

2. The licensee failed to comply with O.Reg 79/10 s. 110 (7) (6), in that Resident #572's restraint assessment, reassessment and monitoring are not documented in the resident's health care record.

Resident #572 has a lap tray with rear clip restraint applied when he/she is seated in a geri-chair. There is no documentation in the resident's health care record documenting the application of the restraint, the assessment, reassessment of the use of the restraint nor the monitoring of the resident's response when the restraint is applied. Two interviewed PSWs confirmed that they were aware that the lap tray with rear clip was a restraint and they confirmed that they are not documenting its' application, the resident's repositioning and monitoring of Resident #572's response to the use of a lap tray. Two interviewed RPNs confirmed that they have not assessed, reassessed the lap tray with rear clip restraint for the Resident #572, nor monitored the resident's response to the use of the restraint. (117)

Resident #501's restraint assessment, reassessment and monitoring were not documented by the registered staff consistently in January, February and March 2012.

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 residents' restraints are applied according to manufacturer's instructions and staff are instructed accordingly and that when a resident is restrained that the resident is assessed, reassessed and the resident's response is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 129 (1) (b) in that the controlled substances are not stored in a separate locked area within the locked medication cart.

Resident # 572's Lorazepam 1mg was observed in the individual dose medication packages located within the medication cart and was not locked within the locked medication cart.

The RPN reported that all regularly scheduled Benzodiazepines are kept in the prepared medication dispensing packages. PRN Benzodiazepines are kept double locked.

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 all controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the O.Reg 79/10 s. 131 (2) is respected in regards to the Resident # 555's insulin medication.

Resident # 555 is diabetic receiving NOVOrapid insulin as per sliding scale three times per day. On March 19 2012, resident #555 left the home on a leave of absence. The home's registered nursing staff prepared and gave the resident's son, the resident's lunch time and evening time medication, to be administered during his/her leave of absence.

Resident # 555 had sufficient NOVOrapid insulin for his/her lunch time medication dose. However he/she did not have enough NOVOrapid insulin to ensure that he/she would receive insulin dosage as per prescribed sliding scale, for his/her supper time insulin dose. The resident had to return to the long-term care home to receive the correct amount of NOVOrapid insulin. The interviewed RN admitted to not verifying the quantity of insulin available to the resident while on a leave of absence from the home.

As such, the registered nursing staff failed to ensure that Resident # 555 had enough NOVOrapid insulin for his/her supper time insulin dose.

2. The licensee failed to comply with O.Reg 79/10 s. 131(3) in that one resident was administered a drug by an unregulated staff member.

On March 26 at 12:00, an RPN crushed Trazadone 50mgs and added it to Resident # 547's chocolate pudding. A dietary aide brought the pudding to the resident and asked the resident to eat the pudding. The RPN did not supervise the resident eating the pudding that contained the Trazadone.

The dietary aide, who served the resident his/her chocolate pudding containing the Trazadone, did not observe the resident eating his/her pudding. Hence, she was unable to report accurately to the RPN the amount of pudding consumed by the resident.

Inspector # 134 reviewed the Medication Administration Sheet (MARS) for March 26, 2012. The RPN had signed the MARS indicating that the Trazadone 50mg had been administered at 12:00. The RPN failed to use the appropriate code to indicate that there would be a progress note entry.

The progress notes were reviewed and there was an entry specifying that Trazadone 50 mg was not fully consumed and that the resident would be monitored.

The MARS and plan of care were reviewed and there are no clear directions for staff on the method of administering Trazadone to Resident # 547. (134)

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 no person administers a drug to a resident in the home unless that person is a physician, registered nurse or registered practical nurse, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The Licensee failed to comply with the O.Reg 79/10 s. 134 (a) in that the home failed to monitor and document Resident # 572 and Resident # 557's responses and effectiveness of prescribed psychotropic drugs.

Resident # 572 was known to be agitated and anxious. In November 2011, the resident's physician ordered a benzodiazepine to be administered daily. The resident became increasingly lethargic after the initiation of the benzodiazepine. The resident's medication was put on-hold at the end of December 2011 for medical reasons. Towards the end of January 2012 the benzodiazepine administration was resumed. Progress notes indicate that since that time, the resident became increasingly lethargic.Two interviewed RPNs and an RN confirmed that the resident is lethargic, and often difficult to arouse. One RPN stated that she sometimes does not give Resident #572 his/her Ativan medication due to his/her ongoing lethargy. The interviewed RPNs stated that they had not assessed, reassessed and monitored the resident's reaction to the benzodiazepine, nor had they mentioned the resident's lethargic status to the unit RN or to the resident's attending physician. (117)

Resident # 557's psychotropic medication dose was increased at mealtimes as per a psycho-geriatrician consult in May 2011. There are several entries in the progress notes that indicate Resident # 557 remains resistive to care. No alternative measures have been considered to address the resident's responsive behaviours. There is no documentation of the monitoring of the resident's response and effectiveness of the psychotropic medication dose increase. (134)

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 when a resident is taking psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk levels, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 16, in that the license failed to ensure that every window in the home that opens outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On March 28, 2012, windows on the main floor in 5 resident rooms open more than 15 centimetres. Windows, in the resident dining rooms, lounges and in the resident care unit (C wing) sitting room, open more than 15 cm, thus creating an elopement risk.

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 ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 33 (1) in that the home failed to provide Resident # 557 and Resident # 01 with 2 baths a week according to their preference and method of bathing.

Resident # 557's Activity of Daily Living flow sheets were reviewed. There are several entries indicating the resident refused his/her shower in January, February and March 2012. There are no entries in the progress notes indicating the reasons why the shower was not given and no indication that the shower was rescheduled.

Two PSWs were interviewed and they reported that Resident # 557 normally refuses his/her shower and no other options are offered to ensure he/she receives two showers per week. The inspector noted a strong urine odour from the resident when in close proximity to his/her. (134)

Resident # 01's Activity of Daily Living flow sheets from December 2011 to March 2012 indicate that the resident refused his/her bath 75% of the time and there are no indications that the baths were rescheduled. There are no interventions identified in the plan of care to direct staff when the resident refuses his/her baths. Two PSW's were interviewed and reported that Resident # 01 usually refuses his/her evening bath because he/she is worried about missing his/her son's visits. The SDM was interviewed and indicated that his /her mother was not always washed. [Log # O-000384-12] (134)

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 ensure that each resident of the home is bathed at a minimum, twice a week by the method of his/her choice and more frequently as determined by the resident's hygiene requirements, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 69 (1), in that the weight changes were not assessed using an interdisciplinary approach for a resident with a change of 5% of body weight over a one month period.

Resident # 580's September 9, 2011 weight was of 92.9 kg. On October 13, 2011, the resident's weight was 84 kg, after returning from a 5 day stay in hospital, a 5 % body weight loss in over one month. The resident's weight loss was not assessed by the home's interdisciplinary team. The home's Registered Dietician assessed the resident's dietary status on November 11, 2011. The assessment and dietary recommendations indicated no change to Resident #580's dietary menu. These were documented in the home's Nutritional Services Manager's assessment binder. The outcome of the Registered Dietician's assessment was not communicated to the rest of the interdisciplinary disciplinary team nor was it documented in the resident's health care record.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s. 31 (2)(4) in that the Licensee did not obtain a physician's order for the application of restraining devices.

Resident # 572 was observed to have a lap tray with rear clip restraint applied when he/she is seated in his/her geri-chair on March 19, 21 22, 28 and 29, 2012. There are no orders by a physician or a registered nurse for the use and application of a lap tray with rear clip restraint in the resident's health care record or in his/her plan of care. (117)

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 the medical orders are received for the use and application of restraints, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 35(2) in that several residents did not receive fingernail care.

Six identified residents were observed to have unclean and untrimmed fingernails.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey
Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 85 (3), in that the home did not seek the advice of the Resident and Family Councils in developing and carrying out the survey and in acting on its results.

The home's CQI coordinator / Clinical Care Coordinator confirmed during the interview that the survey was developed by OMNI Corporation and that the home's Resident and Family Councils were not consulted in the development and carrying out of the 2011 survey, or its implementation.This is confirmed via interviews with the Presidents of the Resident and Family Councils. (117 and 134)

Issued on this 25th day of April, 2012

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

Kathleen Smid

Lyne Duchesne Colette Asselin

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Amended Order of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Kathleen Smid	**Inspector ID #**	161
Log #:	O-000202-12		
Inspection Report #:	2012-044161-0017		
Type of Inspection:	Resident Quality Inspection		
Date of Inspection:	March 15, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, April 2, 3, 4, 5, 2012		
Licensee:	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9		
LTC Home:	ALMONTE COUNTRY HAVEN 333 COUNTRY STREET, P.O. BOX 250, ALMONTE, ON, K0A-1A0		
Name of Administrator:	Marilyn Colton		

To Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Orders, s. 153. (1) (b)

Pursuant to LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order: The Licensee shall prepare, submit and implement a plan for achieving compliance with s. 6 (1) (c) to ensure actions are taken to develop plans of care that are interdisciplinary, individualized and reflective of resident care needs. In particular this plan shall ensure that the written plan of care for each resident provides clear direction to staff. Further, the plan shall include staff training on care plan development, communication and documentation. This plan must be submitted in writing to Inspector Kathleen Smid at 347 Preston St, 4th floor, Ottawa ON, K1S 3J4 or by fax at 1-613-569-9670 on or before April 24, 2012.

Grounds: 1. The licensee failed to comply with the LTCHA 2007 s. 6 (1) (c) in that the residents' plan of care does not give clear direction to staff and to others who provide direct care to residents.

Resident # 01's plan of care does not provide clear direction to staff in regards to the resident's personal hygiene, clothing and bathing needs. The resident is known to refuse care. He/She was observed to wear his/her outdoor coat at all times throughout this inspection. His/Her clothing was observed to be unchanged and soiled during the course of this inspection. His/Her fingernails were noted to be untrimmed and unclean. An interviewed PSW reported that the resident's toenails required cleaning and trimming and that the resident's underwear was soiled. Daily care flow sheets from December 2011 to March 2012 indicate that the resident refused his/her bath 75% of the time and that baths were not rescheduled. There are no interventions identified to direct staff when the resident refuses his/her morning care, nail care, scheduled baths and change of clothing. Also there is no direction to staff to ensure that the resident is wearing appropriate indoor/outdoor clothing. [Log # O-000384-12] (134)

Resident #501's plan of care does not provide clear direction to staff in regards to the resident's risk of falls and use of a safety device. The resident was observed to have a rear fastening lap belt restraint applied for five days in March 2012. The resident's plan of care did not provide clear direction on how to apply the restraint device when the resident is seated in his/her wheelchair and to monitor the resident's response to the use and application of the restraint. The plan of care also provides conflicting information as to the method of transfers and his/her toileting needs: 2-person manual transfer, mechanical lift transfers and weight bearing for toileting transfers. (134)

Resident # 535's plan of care does not provide clear direction to staff as to the type of mechanical lift to be used for his/her transfers, the number of staff required to assist with his/her transfers and as to the resident's mobility. The resident's plan of care currently identifies that the resident is both a manual and mechanical lift transfer. Interviewed a PSW who stated that resident is transferred with a sit-stand mechanical lift. The plan the resident as mobilizing with a walker and it does not identify the resident's observed use of a self propelled wheelchair nor does it identify the observed use of a Personal Assistance Service Device lap belt for safety. (117)

Resident # 557's plan of care does not provide clear direction to staff as to the resident's toileting transfers and his/her incontinence needs. It gives conflicting information regarding his/her toileting transfer needs. It indicates that the resident is to be independent with his/her toileting but is also at risk for falls and requires 2 staff assistance. There is also conflicting information regarding the type of continence product to meet the resident needs and there is a lack of information as to the resident's scheduled toileting plan. As such, the directions to staff related to incontinence are not clear. (134)

Resident # 572 plan of care does not identify and set out clear directions to staff in regards to the removal of facial hair and maintaining the integrity of his/her lips and skin around his/her mouth. The resident repeatedly licks his/her lips and the skin around his/her mouth, causing irritation, redness and chapping. The plan of care does not identify this behaviour, nor the staff's interventions of applying Vaseline, as a skin protection. The plan of care does not identify that the resident has facial hair that requires regular trimming during her scheduled bath. This is validated by two interviewed PSWs. (117)

Resident # 572 is diagnosed as having dementia. He/She is followed by psychogeriatric outreach services. The resident's plan of care does not identify any of the resident's responsive behaviours for which he/she is being seen by the psychogeriatric outreach services. The plan of care does not identify any behavioural triggers, behavioural interventions and does not provide clear direction to staff related to the Resident's anxiety, repetitive tactile behaviours, resistance to care and verbal aggression as identified in the psycho-geriatric assessment of December 2, 2011. (117)

Resident #572 was observed to have a lap tray with rear clip restraint applied when he/she is seated in his/her geri-chair for five days in March 2012. The resident's plan of care does not identify the ongoing use and application of a lap tray with rear clip restraint when he/she is seated in his/her geri-chair. Two interviewed PSWs state that the resident is to be restrained with the lap tray when the resident is seated in his/her geri-chair. (117)

Resident # 576 is identified as being at high risk for falls. The resident's plan of care does not identify the resident's ongoing use of a bed alarm monitoring system as a fall prevention intervention. The bed alarm was observed to be in place and in use one day in March 2012. An interviewed PSW confirmed the daily use of the bed alarm when the resident is in bed. (117) (134)
This order must be complied with by: July 22, 2012

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 31st day of May, 2012.	
Signature of Inspector:	Kathleen Smid
Name of Inspector:	Kathleen Smid
Service Area Office:	Ottawa Service Area Office