Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 29, 2013	2013_230134_0014	O-000797-13	Critical Incident System

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 22 and 23, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN) and several Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) toured the home, reviewed several health care records, the Lifts and Transfer Policy and the Zero Tolerance and Neglect Policy.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007 c.8, section 3(1)2 in that Resident #4 was not respected by one staff member, when confronted by this staff member after having been reported for not complying with safe transfer method.

On a specified date in August, 2013, Resident #4 reported to the charge nurse that staff member #S100 had attempted to transfer him/her using the Maxi-lift alone. There is a transfer logo placed at the head of Resident #4's bed, which clearly specifies that two people are required at all time when transferring the resident using the Maxi Lift.

Resident #4 was interviewed by Inspector #134 on August 22, 2013. The resident told the inspector that on a specified date in August, 2013, staff member #S100 had attempted to do a transfer alone using the Maxi-lift. Resident #4 reported that when he/she had insisted staff member #S100 get someone to help, staff member #S100 replied, "I can do this by myself". Resident #4 categorically refused to be transferred by staff member #S100, who was working alone and proceeded to report the incident to the charge nurse.

Resident #4 reported to the inspector that staff member #S100 came to speak to him/her the next day and had asked if he/she had reported him/her to the RN. Resident #4 indicated to the inspector that he/she was taken back by the way he/she had been approached and questioned by staff member #S100 and added "I felt he/she was not professional and felt he/she should not have said that to me, I felt afraid and uneasy afterwards".

An internal investigation was conducted by management and disciplinary measures were applied as per the Home's Human Resource Policy. [s. 3. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 36, in that one staff member used unsafe transfer technique when assisting Resident #5 from chair to toilet and back.

On a specified date in August 2013, staff member #S100 transferred Resident #5 alone, from chair to toilet using the Sara lift. There is a transfer logo placed at the head of Resident #5's bed, which provides clear direction to staff as to the type of transfer equipment to be used and specifies that 2 people are needed at all times when using the Sara lift.

The Sara/Sara 3000 lift policy # CS-6.15 was reviewed. There is an entry specifying that two staff members shall participate in all residents' lifts and transfers without exception.

Staff member #101, #102, #103, #104 and #105 were interviewed re the policy on lifts and transfers. All replied that all mechanical lift transfers require two staff at all times without exception.

This incident was reported to management who interviewed staff member #S100. Staff member #S100 had admitted to have transferred the resident alone. No injury has been reported as a result of this incident. [s. 36.]

Issued on this 29th day of August, 2013

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

Colette Asselin, LTCH Inspector #134