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

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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
Jul 17, 2014	2014_287548_0018	O-000599-14	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

RUZICA SUBOTIC-HOWELL (548), KATHLEEN SMID (161), LYNE DUCHESNE (117), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): On June 30,2014 and July 2,3,4,7,8,9,10,11, 2014

During the course of the Resident Quality Inspection inspection, CIS Log #:O-000365-14 was conducted concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care, Registered Nursing Staff, Personal Support Workers, RAI Coordinator, Resident Care Coordinator, Environmental Services Manager, Nutrition Care Manager, Registered Dietitian, Maintenance Worker, family members, President of Resident Council and President of Family Council.

During the course of the inspection, the inspector(s) the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed one meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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 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. 15. Accommodation services

Specifically failed to comply with the following:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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 has failed to comply with LTCHA, 2007 S.O. 2007,c.8, s. 15. (2)(a) in that the licensee did not ensure the home, furnishings and equipment are kept clean and sanitary.

On July 4, 2014 during Stage 1 of the Resident Quality Inspection (RQI) it was observed by inspector # 117 that Resident #6's wheelchair wheels and frame were dusty and Resident #3's wheelchair to have food debris on the seating area, lower metal frame and wheels and that the resident's lap belt was soiled with food debris.

On July 7, 2014 during an interview Personal Support Workers(PSWs) S#112 and #113 indicated that it is the PSW's responsibility on nights to clean wheelchairs as assigned. S#113 indicated that once the task is completed it is recorded on the Wheelchair and Walker Cleaning document.

Upon review of the Wheelchair and Walker Cleaning document dated July 6, 2014 it was recorded that these residents' wheelchairs were cleaned.

It was observed on July 7, 2014 that the wheelchairs for both Residents' #6 and #31 remained in the same state of uncleanliness.

It was observed during the Stage 1 of the RQI that the majority of window sills in each resident room were dusty, with debris and dead insects.

On July 7,2014 during an interview, the Environmental Services Manager (ESM) indicated that there is a daily audit completed of the cleanliness of all window sills. S#108 indicated that routinely the window sills are cleaned and when this is completed it is documented on an audit form. S#108 was not able to produce any documentation to support the daily audit of the window sills for June 30, 2014 to July 4, 2014 and confirmed that the audit was not done.

On July 7, 2014 during an interview the Administrator indicated that she was not aware the window sills where is a state of uncleanliness. [s. 15. (2) (a)]

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 by ensuring the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007,S.O. 2007, c.8, s.3(1)1 in that the licensee did not ensure that three Residents were treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On July 2, 2014 at 15:20 hours Inspector # 551 and on July 7, 2014 at 13:53 hours, Inspector #161 observed that Resident #7, who is dependent for care, lying in bed, covered with a sheet, wearing a blouse and continence product

On July 2, 2014 at 14:05 hours, Inspectors #161 and #551 observed that Resident #8, who is dependent for care, was lying in bed, partially covered with a blanket. It was observed that the resident's pants where pulled down to both knees and the continence product was exposed.

On a specified day in July, 2014 at 14:15, Inspector #161 brought the Administrator to the room to observe the status of Resident # 8. The Administrator indicated that this was not acceptable practice in the home.

On July10, 2014 at 15:25, Inspector #548 entered into a 4-bed room and observed Resident # 6 approximately 4 feet above the floor in a sling attached to a mechanical lift which was located partially outside the bathroom and in full view of two of the resident's roommates. Inspector #548 observed that Resident #6's perineum was exposed as one PSW #S127 was providing peri-care and the other PSW #S129 was standing in front of the mechanical lift.

Inspector #548 requested that Registered staff member # S128 accompany her to the Resident's room. On a specified day in July,2014 during an interview both Registered staff members #S 128 and #S130 indicated that providing care without providing privacy was not acceptable practice.

On a specified day in July, 2014 the DOC confirmed that providing privacy to Resident # 6 while providing care was an expectation for all staff members at the home. [s. 3. (1) 1.]

WN #3: 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 in that the licensee did not 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.

Resident #8 has resided at the home since for period of time. It is noted that Resident #8 was assessed by the Registered Dietitian (RD) on a specified day in May, 2014

On a specified day in June, 2014 it is documented in the health care record that Resident #8's had experienced significant weight loss was over a 3 month period.

On July 8, 2014 during an interview the Registered Dietitian (RD) confirmed that it is the RD's responsibility to follow-up on significant weight changes from the information provided to her by the Nutritional Care Manager (NCM). The RD stated that her documentation of the assessment and monitoring related to weight changes would be in the resident's progress notes.

The NCM provided a copy of the "Change in Weight – Summary Report for June 2014" to the inspector which identified residents with significant weight changes for one month, three months and six months.

According to Resident #8's health care record it is noted that the resident was seen on a specified day in May, 2014 by the RD. It is noted there is no documentation to support that Resident 8's weight loss over a 3 month period was assessed by the RD or any other staff member.

Resident #9 has resided at the home for a period of time. It is noted that Resident #9 was assessed by the RD on a specified day in May, 2014.
On a specified day in June, 2014 according to the Resident #9's health care record it is documented that Resident's #9 experienced weight loss over a 6 month period.

It is noted that there is no documentation to support that Resident #9's weight loss was assessed by the RD or any other staff member.

Resident #22 has resided at the home for a period of time. Resident #22 experienced weight loss over a one month and three month period of time.

It is noted on a specified day in March, 2014 in the progress notes that the RD documented that the resident had a significant weight loss over the past month. It is noted the RD charted that she would follow-up next week after the resident had be re-weighed. On a specified day in March, 2014, the RD noted that the re-weigh had not been taken. The next progress note entry by the RD on a specified day in April, 2014. According to the progress notes, there is no documentation to support that the weight loss was assessed.
It is noted that there is no documentation to support that Resident's #22 weight loss over a one month period or within a three month period of time was assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 17th day of July, 2014

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