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

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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 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, Apr 2, Jun 26, 2012	2012_034117_0014	Other

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other 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 Personal Support Workers (PSW), Life Enrichment Coordinator, Maintenance Person, Housekeeping Manager, Dietary Service Manager, as Dietary Aid, several residents and several resident family members.

During the course of the inspection, the inspector(s) reviewed residents' health care records, observed care and services provided to residents, reviewed Quality Improvement Policies, Restraint Policy # CS-5.1, Resident 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, oberved resident mediation passes, observed snack and beverage passes on March 19 and 20, 2012.

It is noted that this report is part of the Resident Quality Inspection (RQI) # 2012-044161-0017. The findings below were integrated and issued in the RQI report. Please refer to this report for detailed information on the findings. The RQI report is the official report document for this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Quality Improvement

Responsive Behaviours

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. 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 # 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 # 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)

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 # 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)

WN #2: 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 she is seated in her geri-chair on a 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 her plan of care. (117) (

WN #3: 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 :

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)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

Issued initially identified in this O.Reg were issued under section 134 (a) - please refer to this section

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WN #5: 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. Mar 27, 2012 - 19:54 - The licensee failed to ensure that the O.Reg 79/10 section 69 is respected related to weight changes are assessed using an interdisciplinary approach, and that action are taken and outcomes are evaluated for residents 1) when a change of 5 percent of body weight or more, over one month occurs.

The resident Albert Pitcher September 9,2011 weight was of 92.9 kg. On October 13, 2011, Pitcher'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 multidisciplinary team. The home's Registered Dietician assessed the resident's dietary status on November 11 2011. The assessment and dietary recommendations, no change to Pitcher's dietary menu, were documented in the home's Nutritional Services Manager assessment binder. The outcome of the Registered Dietician's dietary assessment was not communicated to the rest of the multidisciplinary team nor was it documented in the resident's health care record.

WN #6: 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. (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 (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)

WN #7: 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).

Findings/Faits saillants :

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.

WN #8: 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 :

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)

Issued on this 26th day of June, 2012

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