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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2015	2015_288549_0019	O-002282-15	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

RENA BOWEN (549), MEGAN MACPHAIL (551), RUZICA SUBOTIC-HOWELL (548)

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): July 6, 7, 8, 9, 10, 13, 14, 15, 16, 2015

Log # O-002196-15 was inspected concurrently

During the course of the inspection, the inspector(s) spoke with Residents, President of Resident Council, President of Family Council, Personal support workers (PSW), Registered
Practical Nurses (RPN), Registered Nurses (RN), Food Service aides, Food Service Manager, Housekeeping support aides, Maintenance workers, Resident Care Coordinator, Physio Therapist, Physio Therapy aid,Director of Care (DOC), and the Administrator.
The inspectors also toured residential and non residential areas (including medication rooms), reviewed several resident health care records, observed meal services, observed a medication pass, reviewed the cleaning schedule for resident wheelchairs and walkers, housekeeping routines, several of the home's policies and procedures relating to lifts, fall prevention and management, skin and wound care and the home's complaints procedure and manufacturers instructions for the lifts.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 ensure that the home, furnishing and equipment are kept clean and sanitary.

On July 7, 2015 Inspector #551 observed Resident # 9's wheelchair to be visibly soiled.

On July 14, 2015 Inspector #549 observed the following:

Resident #9's wheelchair had dried debris on the wheelchair frame around the braking system and the seat.

Resident # 8's wheelchair had dried debris on the front of the wheelchair seat by the cushion.

Resident #13 had what appeared to be dried cereal down the front right chair frame and into the circular opening above the wheel.

Resident #42's wheelchair frame under the seat was covered in a thick layer of dust.

On July 14, 2015 during an interview the DOC indicated to Inspector #549 that the night shift PSWs are assigned the cleaning of the resident's walkers and wheelchairs as part of their regular night duties.

Each resident's wheelchair and walker is cleaned on the night shift once a month. The wheelchair/walker cleaning list titled Almonte Country Haven: W/C and Walker Cleaning indicates two wheelchairs and one walker per corridor are cleaned each night.

The DOC was unable to provide Inspector #549 with documentation indicating which wheelchairs were cleaned during the night shift for the month of June 2015.

During an interview on July 14, 2015 the DOC indicated to Inspector #549 that the expectation of the home is that in-between detailed scheduled cleaning days PSWs are to wipe off any visible dirt or debris from the resident's wheelchair or walker when required.

Inspector #549 observed the wheelchairs of Resident # 8, #9, #13 and #42 on July 15, 2105 at 10:45. All of the indicated wheelchairs had the same dried debris and dust on them. [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 to ensure that the residents wheelchairs are kept clean and sanitary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is on at all times.

The home is equipped with an audio/visual resident-staff communication and response system (the system). When activated an audible sound is heard and a light indicating where the signal is coming from illuminates near the point of activation. An audible sound and a red light illuminates at the nursing station also indicating where the system was activated.

On July 7, 2015 when Inspector #549 activated the system in the resident's main lounge the light indicator did not come on and the sound to alert staff was not audible.

During an interview with maintenance worker #118 on July 10, 2015 it was indicated to Inspector #549 that the system in the resident's main lounge area was disconnected from the main panel. The maintenance worker was not aware of when the system in the main lounge was disconnection but thought it might have occurred with the last upgrade in error. The maintenance worker indicated that the home's service provider would be contacted to reconnect the system for the resident's main lounge.

During an interview with the Administrator on July 14, 2015 it was confirmed with Inspector #549 that the home's service provider was contacted and requested to reconnect the system in the resident's main lounge area. [s. 17. (1) (b)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

The home is equipped with an audio/visual resident-staff communication and response system (the system), which is available at each bed, toilet, and bath/shower location, as identified during the inspection.

On July 7, 2015 it was observed by Inspector #549 that the Private Dining Room/Care Conference/Sun Room which is located at the end of the Cardinal Lane corridor was not equipped with a resident-staff communication and response system.

On July 9, 2015 the Administrator and the DOC confirmed that the Private Dining/Care Conference/Sun Room is an area accessible by residents.

The Administrator and the DOC also confirmed that the Private Dining/Care Conference/Sun Room does not have a system in the room.

During a discussion with the maintenance worker #118 on July 10, 2015 it was indicated to Inspector #549 that the system in the Private Dining/Care Conference/Sun Room was removed. The maintenance worker could not recall when the system was removed. The maintenance worker indicated that the room was used as an office area previous to being utilized as a resident accessible area and might have been when the system was

removed.

On July 14, 2014 the Administrator confirmed with Inspector #549 that the home's resident-staff communication and response system service provider has been contacted and will be reinstalling the system in the Private Dining Room/Care Conference/Sun Room. [s. 17. (1) (e)]

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 the resident-staff communication and response system is on at all times and that there is a resident communication and response system available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use the Arjo Calypso equipment in accordance with the manufacturer's instructions.

The home has three tub rooms and each has a Calypso lift hygiene chair (tub chair). The lift hygiene chairs in the Finch and Cardinal corridors have curved transport handles. The lift hygiene chair in the Blue Jay corridor has straight transport handles.

The Clinical Care Coordinator provided Inspector #551 with the manufacturer's instructions for the Calypso lift hygiene chair on July 15, 2015. The Clinical Care Coordinator indicated that the manufacturer's instructions are for all three Calypso lift hygiene chairs.

The manufacturer's instructions indicate that the Calypso lift hygiene chairs are supplied with a safety belt. On page 4 of the manufacturer's instructions it states that "the safety belt must be used at all times to make sure the resident remains in an upright position in the middle of the seat. The safety belt must be attached to the seat of the Calypso on the same side as the backrest and securely fastened with the buckle". On page 5 the manufacturer's instructions state "the Calypso is moved with care, especially in narrow passages, over bumps etc. and that the resident safety straps are secured". On page 10 the manufacturer's instructions state" the safety belt should be used all the time when the resident is moved. Attach the belt to the transport handle and place it in front of the resident and fasten it to the knob".

During the inspection, it was observed by Inspector #551 that there were no safety belts attached to any of the three calypso lift hygiene chair.

PSW #103 indicated to Inspector #551 and #549 that there was a safety belt for the Calypso lift hygiene chair but has not seen it for quite a long time. PSW #103 indicated that he does not know where the safety belt has gone.

PSWs #114, #103 and #113 were interviewed. Each PSW provides bathing care to residents and each stated that safety belts are not used with the tub chairs.

The DOC indicated that the home did not use safety belts with the lift hygiene chairs as she was under the impression that all three lift hygiene chairs had curved transport handles which negated the need for a seat belt.

Upon becoming aware that safety belts were to be used with all three lift hygiene chairs, the DOC indicated that no resident would receive a bath until the safety belts were installed.

On July 16, 2015 the DOC indicated that the home has ordered new safety belts from the Calypso lift hygiene chair supplier. [s. 23.]

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 the Arjo Calypso lift hygiene chair is being used in accordance with the manufacturers' instructions, to be implemented voluntarily.

WN #4: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #24 was admitted to the home on a specific date in March, 2015. A Braden Scale for Predicting Sore Risk was completed and indicated that the resident was a moderate risk for pressure sores. Resident #24 was also assessed as being a moderate nutritional risk.

On July 7, 2015 Inspector #549 observed bruising on Resident #24's forearms.

During an interview on July 13, 2015 RPN #104 indicated to Inspector #549 that the resident received the bruises while attempting to transfer alone from the bed to the wheelchair using the transfer pole and from moving in bed and hitting the right bed rail.

Resident #24 has limited use of a limb and mobility, on and off the unit, is restricted to a wheelchair. Resident #24 was observed by Inspector #549 to spend most of the day either in a wheelchair or in bed. RPN # 104 indicated this is the resident's normal daily activity.

Resident #24's current plan of care was reviewed with the Clinical Care Coordinator and the Resident Care Coordinator. Inspector #549 was unable to locate the planned care directions for staff and others who provide care to the resident related to Resident #24's skin care.

Inspector #549 interviewed several PSWs on several shifts, all indicated that they are not aware of any skincare requirements for Resident #24's skin integrity. The PSWs were unable to locate the care set out in the written plan of care related to skin care for Resident #24.

On July 13, 2015, the DOC confirmed with Inspector #549 that the home's expectation is that a written plan of care that sets out the planned care for Resident #24 related to the resident's skin care be developed. [s. 6. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #8's bedtimes and rest routines are supported and individualized to promote comfort, rest and sleep.

Resident #08 has resided at the home since a specific date in January 2015.

On July 7, 2015, Resident #8 stated to Inspector #551 that he/she did not participate in choosing when to get up in the morning. Resident #8 stated that in the morning staff got him/her up earlier than he/she preferred and stated that it meant more time sitting in a wheelchair with nothing to do.

On July 15, 2015, Resident #8 stated that he/she does not like getting out of his/her warm bed and being brought to the lounge. Resident#8 stated that his/her preference is to get up for breakfast but not hours in advance.

PSW #110 stated that when she starts her shift at seven in the morning, Resident #8 is up in a wheelchair and dressed in day clothes most days.

On July 15, 2015, PSW #119 stated that when she started her shift at seven this morning, Resident #8 was up and dressed in day clothes.

RPN #100 confirmed that most days when she starts her shift at seven am, Resident #8 is up and sitting in the front lounge.

The Resident Care Coordinator stated that residents' sleep patterns and preferences are located in the plan of care. She stated that sleep patterns and preferences are discussed on admission, and if specified will be added to the plan of care at that time. Otherwise sleep patterns and preferences are added to the plan of care as residents' routines are established and known such as during the quarterly assessment or at morning meetings.

Resident #8's written plan of care was reviewed by Inspector #551, and the desired bedtimes and rest routines are not supported to promote, rest and sleep. [s. 41.]

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:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that no resident administers a drug to him/herself unless the administration has been approved by the prescriber in consultation with the resident.

On July 7, 2015 during an interview Resident #31 indicated to Inspector #548 that he/she had been experiencing a burning and pain sensation in his/her hands and was prescribed a specific medication for the discomfort.

The resident showed Inspector #548 that he/she carried the specific medication with him/her. The resident indicated that he/she does this so that he/she can "apply this to myself".

During a record review it was noted on the Physician Order form on a specific date in July, 2015 that the medication was ordered. The physician orders do not indicate that the resident is to self- administer the medication.

On July 9, 2015 Resident #31 showed the inspector that he/she continued to carry the drug with him/her and had applied the medication to him/herself twice a day.

On July 9, 2015 during an interview the DOC indicated that the home has no residents' who self- administer their own medications and that this is not the practise at the home. [s. 131. (5)]

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Issued on this 23rd day of July, 2015

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

Original report signed by the inspector.