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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 14, 2016	2016_287548_0015	008396-16, 014226-16, 017960-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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)

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): June 20, 2016 and July 4,5,6, 2016

Observed residents, staff to resident interaction, observed resident bedrooms, reviewed resident health care records, operational manual and home policies.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse, Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Clinical Care Coordinator, RAI Coordinator and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 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 ensure staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #003 was found sitting on the floor beside the toilet with the lift sling around his/her waist on a specified day in June 2016. A critical incident report was completed and submitted to the MOHLTC on a specified day in June 2016 indicating the resident had been placed on the toilet with the use of the stand lift and then was left unattended.

The health care record and policies were reviewed.

The resident's #003 current care plan dated for a specified day in March 2016 indicated that the mechanical lift is to be used for all transfers; this intervention began on a specified day in January 2015. The care plan specifies that the resident #003 was not to be alone while toileting for safety reasons.

On July 6, 2016 during an interview PSW #104 and PSW #110 both indicated that the resident #003 is able to vocalize his/her needs and is comfortable with the use of the mechanical lift. Both indicated that the resident is assisted to a sitting position for toileting and is not to be left alone as he/she will attempt to remove the sling from the lift. Both indicated that the lift is still attached to the sling while the resident is seated on the toilet.

On July 6, 2016 during an interview the DOC indicated that the resident #003 was assisted by two staff members to the toilet via lift with the sling around the resident's waist and attached to the lift.

The home's policy SARA/SARA2000/SARA3000 Lift, CS- 6-.15, Effective Date January 2011 specifies that the when a resident is lowered to the toilet the sling is to be removed from the resident. [s. 36.]

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 staff use safe transferring and positioning devices as instructed, to be implemented voluntarily.

WN #2: 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The Licensee failed to ensure the plan of care set out clear directions to staff and others who provide care to the resident.

A critical incident report Log#: 014226-16 was submitted on a specified day in May 2016 describing an incident that resulted in an injury when the resident was transferred by two staff members to a shower chair. The resident sustained an injury to a body part that was attended to by a physician.

The health care record was reviewed.

Resident #002 Minimum Data Set assessment (MDS) was completed on a specified day in April 2016 indicating that the resident required extensive assistance with two persons assisting with transfers and was to be lifted mechanically.

The resident's #002 care plan dated for a specified day in March 2016 indicated that the resident was a two person physical assist and was to be lifted mechanically using a Maxi Lift for transfers between surfaces. The care plan specifies that staff observe the "Transfer logo sign posted over the bed".

On July 5, 2016 the inspector observed the Transfer Logo picture to depict a resident in a lift.

The home's policy, Principles for Lifting and Transferring, CS-6.1, Effective Date: January 2011 indicates that residents are to be provided a safe method of transfer to minimize the risk of injury to the resident.

On July 5, 2016 during an interview PSW #104 indicated that the resident is to be transferred between all surfaces using a sling lift. PSW #104 indicated that this is the preferred method as the resident can be resistive to care. RPN #105 indicated the resident was to be a transferred via lift and was not certain why the care plan reflected two different interventions. The RAI coordinator indicated that he was not aware there were two transfer interventions care planned.

On July 5, 2016 during an interview the DOC indicated that the sustained injury must have been attributed to the resident's extermity being alongside the wheelchair foot pedal post. She indicated that when the two PSWs transferred the resident to the shower chair, the edge of the post caused an injury. The DOC indicated the two PSW's #108 and #109 involved in the incident were aware that resident #002 required the use of a lift for all transfers as the signage depicted this. [s. 6. (1) (c)]

2. The Licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A critical incident report, Log #: 017960-16 was submitted to the MOHLTC on a specified day in June 2016 for an incident earlier that month. The CIR indicated the resident had been placed on the toilet with the use of the stand lift and was left unattended. Resident #003 was found sitting on the floor beside the toilet with the lift sling around his/her waist.

The health care record and policies were reviewed.

Resident #003 Minimum Data Set assessment (MDS) completed on a specified day in May 2016 indicated that the resident required extensive assistance with transfers and has limited range of motion to a body part. The triggered Resident Assessment Protocols (RAP) Item for Falls indicated that the resident is at a medium risk for falls due the daily use of an antidepressant.

The resident's #003 current care plan dated for a specified day in March 2016 indicated that a mechanical lift is to be used for all transfers; this intervention began on a specified day in January 2015. The care plan specified that the resident #003 is not to be alone

while toileting for safety reasons. Resident's #003 Logo was observed on July 6, 2016 by Inspector #548 it specifies - "Sara Lift, two persons" at the resident's bedside.

On July 6, 2016 during an interview PSW #104 and PSW #110 both indicated that the resident #003 is able to vocalize his/her needs and is comfortable with the use of the Sara lift. Both indicated that the resident is assisted to a sitting position for toileting and is not to be left alone as he/she will attempt to remove the sling from the lift.

On July 6, 2016 during an interview the DOC indicated that the resident #003 was assisted by two staff members to the toilet via lift and left unattended. The DOC indicated that PSW# 106 was assisting PSW#107 to toilet the resident and both PSWs walked away from the resident outside the bathroom to the resident's bedroom door. PSW# 107 proceeded to go to lunch and PSW #106 proceeded to answer other call bells.

The resident was found by two other staff members on the bathroom floor with the sling around his/her waist. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee failed to inform the Director no later than one business day of an incident that caused injury to a resident for which the resident was taken to hospital.

Resident #001 had a significant change of health status due to a fall on specified day in February 2016 where resident #001 sustained an injury requiring a transfer to hospital. The incident was reported to the MOHLTC several days post incident, Log #: 008396-16.

The Administrator and DOC share the responsibility to complete critical incident reports.

On June 20, 2016 during an interview the DOC reported she is not certain why the critical incident was not reported. The Administrator concurred this statement on July 12, 2016. [s. 107. (3) 4.]

Issued on this 14th day of July, 2016

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

Original report signed by the inspector.