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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_582548_0022	013468-17	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. BOX250 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): October 19 and 26, 2017

The Inspector reviewed the resident's health care record and observed the resident

During the course of the inspection, the inspector(s) spoke with Resident, Director of Care, RAI Coordinator, Personal Support Worker

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

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

- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The Licensee failed to ensure that the provision of the care set out in the plan of care is documented for resident #001.

A Critical Incident Report was submitted to the Director related to an alleged neglect. A staff member found resident #001 to be incontinent and saturated.

Resident #001 requires assistance with all activities of daily living. The resident's current care plan specifies toileting interventions and the type of incontinence products that are to be used.

During an interview on October 26, 2017 with Inspector #548 the RAI coordinator indicated that Personal Support Workers (PSWs) are to record on the PSW 'Flowsheet' the number of times a resident is toileted. She indicated that the toileting interventions specified the number of times the resident #001 is to be toileted. She indicated that each individual entry made by the PSW in the flowsheet would be the number of times the resident is toileted or changed during a specific period of time.

Review of the PSW "Flowsheet' for a specified period of time in June 2017 was conducted by the Inspector #548 in the presence of the RAI coordinator. It is recorded that the resident was toileted once on a specified time and day. During the specified period of time it was recorded that the majority of time the resident #001 was toileted only once during a specified period of time during the day whereas, her toileting interventions specified twice during that period of time.

During an interview with Inspector #548 the resident #001 indicated that the toileting routine is maintained however, for this particular instance it was not provided.

During an interview on October 19, 2017 with Inspector #548 the Director of Care indicated that the resident was to be toileted as specified in her plan of care and that the PSW involved was disciplined.

The Licensee failed to ensure that the provision of care that is provided to resident #001 is documented. [s. 6. (9) 1.]

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.