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
Dec 22, 2017	2017_593573_0028	024727-17	Resident Quality Inspection

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

ANANDRAJ NATARAJAN (573), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 04, 05, 06, 07, 08, 11, 12, 13 and 18, 2017.

The following Follow up and Critical Incident inspections were conducted concurrently during this Resident Quality Inspection;
1) Log #026434-17 was inspected related to Compliance Order #001 from a Complaint Inspection #2017_582548_0020 issued on November 17, 2017, regarding a resident care.
2) Log #021612-17 was inspected related to an incident that caused an injury to a resident for which resident was transferred to hospital.
3) Log #025993-17 related to staff to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinator, RAI Coordinator, Life Enrichment Coordinator, Environmental Services Manager (ESM), Food Services Manager, Physiotherapist, Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Personnel, Housekeeping Aides, Activity/ Recreation staff members, Dietary Aides, Cooks, President of Residents' Council, Chair of the Family Council, Family members and Residents.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed medication administration passes, recreation activities, exercise therapy classes, meal and snack services, reviewed residents health care records, the licensee's relevant policies and procedures, staff work routines, minutes for Residents' and Family Council. In addition, Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_582548_0020	549

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee submitted Critical Incident Report (CIR) on a identified date in 2017. The CIR indicated that PSW #118 was providing care to resident #023. PSW #118 requested that PSW #102 assist him as the resident required assistance for the care. While providing care the resident became combative and uncooperative. The resident began to strike out and yell at the PSWs, the PSWs continued to provide the care. RPN #114 observed significant injury on resident's specific body part when the resident was brought to the dining room after the care was provided by the PSWs.

Resident #023 was admitted in the home with multiple diagnosis. Resident #023's Minimum Data Set (MDS) assessment on a specified date indicates that the resident's cognitive skills for daily decision making were impaired.

The resident #23's written plan of care in place at the time of the incident which was provided by the RAI-Coordinator was reviewed by the Inspector. The written plan of care indicated that the resident requires verbal cuing and one person assist if there is difficulty. The written plan of care also indicated if the resident is refusing care staff are to attempt to determine the reason for refusing. If the resident continues to refuse, ensure safety, leave and return in a few minutes to re-offer.

Inspector #549 was unable to interview PSW #118 as he is no longer an employee of the home.

During an interview with PSW #102 on December 11, 2017, it was indicated to Inspector #549 that when she went into resident #023's room the resident was lying in the bed. PSW #118 required the assistance of PSW #102 to use the mechanical lift to get the resident out of bed into a chair. PSW #102 indicated to the Inspector that when she entered the room the resident was calling for a doctor and was visibly upset. The resident was angry and began hitting both PSW's as they used the mechanical lift to transfer the resident to a chair. At the time of the transfer PSW #102 indicated that the resident refused to hold on to the lift. PSW #102 indicated that the resident was lifted to the chair where they completed the resident's care. PSW #102 indicated that she put her arm across the front of the resident so the resident would not hit them. PSW #102 also indicated that she does not know if the resident was resistive to care when PSW #118 was providing care to the resident as she was not present. PSW #102 indicated to the inspector that she continued with the care even though the resident was resistive for

care. PSW #102 indicated to the inspector that she realizes now that she should have left the resident and returned later and not force care upon the resident. The PSW also indicated that she did not notice any injury when the resident's care was completed. She did however inform the Charge Nurse that the resident was resistive to care after the care was provided.

During an interview with RPN # 114 on December 11, 2017, it was indicated to Inspector #549 that she observed the significant injury on resident #023's specific body part when the resident was brought to the dining room on a specified date. RPN #114 immediately notified management of the incident.

The licensee's Zero Tolerance of Abuse and Neglect of Residents policy #AM-6.9 provided to the inspector by the DOC was reviewed. The licensee's definition of physical abuse found on page two of the policy indicates that "the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with the Administrator on December 13, 2017, it was indicated to the Inspector that the home's expectation is that resident care be stopped when a resident is resistive to the care and be re-approached later not force care upon an unwilling resident. The Administrator also indicated that the home's expectation is that all staff comply with the licensee's Zero Tolerance of Abuse and Neglect of Residents policy #AM-6.9.

As such, the licensee failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with when PSW #102 and PSW #118 forced care upon resident #023 on a specified date resulting in significant injury. (Log #025993-17) [s. 20. (1)]

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 licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied the physical device for restraining a resident in accordance with manufacturer's instructions.

On a identified date and time, Inspector #573 observed resident #042 to be sliding down in a wheelchair. At the time of the observation, resident #042 was wearing a wheel chair seat belt, which was positioned around the resident's chest. RPN #116 was made aware, at which time resident #042 was repositioned in the wheel chair by the PSW staff members. Upon resident's repositioning in the wheel chair Inspector #573 observed resident #042's wheel chair seat belt was not positioned across the hips and had approximately more than five finger gap between the belt and the resident's hips.

Inspector #573 spoke with the RPN #116, who indicated to the Inspector that resident #042's wheelchair seat belt was loose and she will place a referral to the home's physiotherapist for a seat belt reassessment.

On an identified date and time, Inspector #573 observed resident #010 sitting in a

wheelchair with a seat belt that was not positioned across the hips and had approximately more than six finger gap between the seat belt and the resident's hips. Resident #010's wheelchair seat belt was examined by the physiotherapist in the presence of the Inspector, the physiotherapist indicated to inspector that the resident's seat belt was loose and immediately readjusted the seat belt. The physiotherapist indicated that resident #010's wheel chair seat belt needed further readjustment from the anchor point which is to be done by the wheelchair technician.

Resident #042 and #010 health care records were reviewed by Inspector #573. In both the residents' health records, the use for wheel chair seat belt was identified as physical restraints.

Inspector reviewed the Body point Four-Point Center-Pull Padded Hip Wheelchair Belt manufacturer's instructions as provided by the home's physiotherapist. The manufacturer's instructions indicated "Keep belt tightened during fitting, and maintain this tightness during daily use to ensure correct placement". In the "Installation and User Instructions section, under the third warning indicates "This pelvic support belt must be worn tightly fitted across the lower pelvis or thighs at all times. A loose belt can allow the user to slip down and create a risk of strangulation. Have your seating specialist demonstrate its proper adjustment and use".

On December 12, 2017, the home's physiotherapist who was an Assistive Devices Program (ADP) authorizer indicated to Inspector #573 that the expectation regarding the application of the wheel chair seat belt was that it should be a snug fit, two to three fingers gap between the seat belt and the resident's hips. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On a identified date, Inspector #573 observed resident #002 and resident #010 sitting in their wheelchairs each with front closing seat belt in place.

A review of resident #002 and #010's written plans of care indicated the use of front closing seat belt as a restraint. Inspector #573 reviewed resident #002 and #010's health care records for restraint which included the SDM's consent and a corresponding

physician's order for the use of wheelchair seat belt as a restraint.

On December 08, 2017, Inspector #573 spoke with RPN #115 who indicated that the residents with restraints are monitored hourly by the PSW staff, who document the application, release and repositioning of the resident in the Restraint/ PASD monitoring and repositioning record binder. Further, she indicated that the registered nursing staff will reassess the resident's response and the effectiveness of the restraint, every eight hours which is recorded in the Medication/ Treatment Administration Record (MAR/ TAR).

Inspector #573 reviewed the MAR/ TAR documentation for resident #002 and #010 in the presence of RPN #115. Upon review it was observed that there was no records in the resident's MAR/ TAR to demonstrate that the residents' condition and effectiveness of the seat belt restraint had been reassessed at least every eight hours by the registered nursing staff. The RPN indicated to the Inspector that if a resident's restraints in the MAR/ TAR system does not prompt for a reassessment, then the registered nursing staff may not reassess the resident for the effectiveness of restraint at every eight hours.

On December 08, 2017, Inspector #573 spoke with the home's DOC, who agreed with the Inspector that resident #002 and #010 were not reassessed for the effectiveness of the restraining every eight hours by the registered nursing staff. [s. 110. (2) 6.]

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 staff apply physical devices for restraining a resident in accordance with manufacturer's instructions and the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour in the home on December 04, 2017, Inspector #573 observed that the door to the laundry room and the door to the mop room, both located in the D wing corridor, were closed but unlocked. Inspector #573 observed that the laundry room contained the following; Industrial washing machine, dryer and other various laundry equipment's and products. There were no staffs in the area supervising the door. Although the laundry room door is equipped with a lock, it was not kept locked in order to restrict unsupervised access to the laundry room.

On December 08, 2017, Inspector #573 observed the mop room door in the D wing corridor that was kept unlocked. Inspector observed various cleaning products for housekeeping purposes that was kept inside the mop room.

On December 08, 2017, Inspector #573 observed the mop room that was not kept locked in the presence of the home's Administrator. The Administrator indicated to the Inspector that the expectation was that the mop room and the laundry room door to be kept closed and locked at all times when the area is not supervised by staff.

On December 12, 2017, the Administrator spoke with Inspector #573 who indicated that the mop room and the laundry room door locks has been replaced by the maintenance personnel. Further, she indicated to the Inspector that the mop room and the laundry room door lock will engaged as soon as the door is closed and required a key to un-engage the lock. [s. 9. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

During the initial tour in the home on December 04, 2017, Inspector #573 observed that the residents shower room at the B wing corridor were not equipped with any grab bars to the wall. Inspector #573 spoke to PSW #101 who indicated that the shower room in the B wing was actively used for the residents who require a shower. Further she indicated that there were few residents who prefer to have their shower in standing position.

On December 08, 2017, Inspector #573 observed the B wing shower room in the presence of home's ESM. The ESM agreed with Inspector #573 that the shower room identified by the Inspector was not equipped with any grab bars. Further, the ESM indicated that a maintenance work order will be placed immediately to install garb bars in the identified shower room.

On December 18, 2017, Inspector #573 observed the B wing shower room that was installed with two shower grab bars as per the legislative requirements. [s. 14.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of: i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. one other staff member appointed by the Director of Nursing.

During a medication pass observation on December 11, 2017, Registered Nurse (RN) #113 indicated to Inspector #549 that when a non-controlled drug is to be destroyed the RPN or RN on that particular shift will put the drug to be destroyed in the Stericycle destruction container. The Stericycle destruction container is kept in the medication room in a locked cupboard.

RN #113 indicated that there is only one registered nursing staff acting alone when putting non-controlled drugs into the Stericycle container for destruction.

During an interview with the DOC on December 11, 2017, it was indicated to the Inspector that she was not aware that the non-controlled drugs to be destroyed were required to be done by a team acting together, one a member of the registered nursing staff appointed by the DOC and one other staff member appointed by the DOC.

As such, the licensee failed to ensure that non-controlled drugs to be destroyed is done with by a team acting together, one member of the registered nursing staff appointed by the DOC and one other staff member appointed by the DOC. [s. 136. (3) (b)] [s. 136. (3) (b)]

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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

Issued on this 29th day of December, 2017

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

Original report signed by the inspector.