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
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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
Oct 12, 13, 14, 27, 28, Nov 1, 2, 2011	2011_029134_0011	Complaint

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Registered Nurse (RN), three Registered Practical Nurses (RPN), the Attending physician, several Personal Support Workers (PSW), one resident and four family members.

During the course of the inspection, the inspector conducted 4 complaint inspections - log numbers, O-001825, O-002219-11, O-002036 and O-000787.

During the course of the inspection, the inspector(s) reviewed three residents' health records, the Home's Standing Orders For Palliative Care and the Registered Staff's time sheet, several letters from family members and the Licensee's response to those letters.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Medication

Pain

Responsive Behaviours

Sufficient Staffing

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with section 6 (5) in that the Substitute Decision Maker (SDM) was not given an opportunity to participate fully in the implementation of the plan of care. The SDM did not receive enough information related to palliative care to make an informed decision.

There is an entry made in one identified resident's progress notes indicating the physician ordered Resperdol. This identified resident's SDM reported to the inspector that there was insufficient information provided related to this medication to allow for an informed decision.

There is an entry in this resident's progress notes indicating "resident was designated Palliative by the physician and orders were received for Palliative Standing Orders to be followed".

The SDM, reported to the inspector that insufficient information was provided as it related to pain medication and Palliative Standing Orders to allow full participation in the identified resident's plan of care.

Log # O-001825-11

There is an entry in a second identified resident's progress notes indicating the physician had witnessed an episode of hallucinations and ordered Haldol twice a day as needed.

Haldol was given. There is no entry in the resident's progress notes to indicate the SDM was notified of this order. The SDM was not given the opportunity to fully participate in the resident's plan of care when the condition changed.

Log # O-002036-11

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 the residents' SDMs are given an opportunity to participate fully in the implementation of the plan of care by providing them enough information so they can make an informed decision prior to the administration of medication and/or treatment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The following instances show that the licensee failed to comply with s. 117(b) to ensure that no medical directives for the administration of a drug is used unless it is individualized to the resident's condition and needs.

The licensee has "Standing Orders for Palliative Care Residents", which were approved October 2007, by the Professional Advisory Committee of the Home.

The Standing Orders provide a list of medical conditions with indications for administering different medications or treatment.

One identified resident was diagnosed as being palliative. There is an entry in this resident's progress notes indicating Scopolamine and Ativan were administered as per the Palliative Standing Orders.

This identified resident was administered Scopolamine and Ativan from the Standing Orders, these medications were not individualized to the resident's condition and needs.

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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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The following findings show the Licensee did not comply with s. 131(1) related to the prescribing and administration of drugs.

There is an entry in one identified resident's progress notes indicating Scopolamine and Ativan were administered as per the Palliative Standing Orders.

The Scopolamine and Ativan were not prescribed for this resident.

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Issued on this 4th day of November, 2011

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

Colette Asselin, LTCH Inspector #134