Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 1, 2021	2021_909732_0028	012830-21	Critical Incident System

Licensee/Titulaire de permis

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

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

EMILY PRIOR (732)

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): November 25, 26, and 29, 2021.

During this Critical Incident (CI) System inspection, log #012830-21 (CI #2692-000003-21) related to alleged resident to resident abuse and responsive behaviours was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Director of Care (DOC), the Clinical Care Coordinator, the Environmental Services Manager, Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector(s) also observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, resident home and care environments, infection prevention and control (IPAC) measures; as well as reviewed resident health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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 has failed to ensure that the care set out in resident #001's plan of care was documented.

A resident had an incident of physically responsive behaviour towards another resident. The RPN initiated the Behavioural Supports Ontario – Dementia Observation System (BSO-DOS) Data Collection Sheet to monitor the resident's behaviour.

The licensee's Dementia Observation System (DOS) Policy, described that the purpose of DOS is to provide documented analysis of new or changed responsive behaviours for an existing resident. The DOS shall be completed daily as follows: Resident status shall be documented in the appropriate box on 30 minute intervals over a 24 hour period for a minimum of 5 days by the PSW staff or designate.

Upon review of the resident's DOS charting, it was noted that there was no documentation for a period of 5 hours on one of the days. The Clinical Care Coordinator confirmed that this should have been completed.

Sources: resident #001's progress notes; resident #001's health care record; Dementia Observation System (DOS) Policy: #SM-1.9, reviewed/updated: September 4, 2019; and interviews with the Clinical Care Coordinator, and other staff. [s. 6. (9) 1.]

Issued on this 1st day of December, 2021

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

Original report signed by the inspector.