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
Feb 3, 2022	2022_966755_0001	013982-21, 014476-21, 014799-21, 015601-21, 018953-21	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

MANON NIGHBOR (755)

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): January 19-21, 24-27, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #013982-21 (CIS #2692-000007-21); log #014476-21 (CIS #2692-000009-21); log #015601-21 (CIS #2692-000012-21); log #018953-21 (CIS #2692-000016-21) related to resident to resident physical responsive behaviours. Log #014799-21 (CIS #2692-000011-21) related to resident to resident sexual responsive behaviour.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Assessment Instrument Coordinator (Rai Coordinator), Clinical Care Coordinator, Infection Prevention and Control Specialist, Nursing Administrative Services Manager, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff member and resident.

During the course of the inspection, the inspector reviewed related clinical health records, relevant home policy and procedure, conducted interviews and made observations of resident and staff interactions and care provision.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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)
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	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 :

The Licensee has failed to ensure that the provision, outcome and effectiveness of the care set out in the plan of care was documented.

The Behavourial Supports Ontario-Dementia Observation System Worksheets (BSO-DOS), the 24 Hour Safety Check-Q 30 mins and the Neurological Vital Signs Post Head Injury forms' documentation were incomplete.

Three residents had incidents of responsive behaviour towards other residents. The BSO-DOS and the 24 Hour Safety Check Q 30mins forms were initiated to monitor the residents' behaviours.

The licensee's Dementia Observation System (DOS) Policy #SM-1.9, described that the purpose of BSO-DOS is to provide documented analysis of new or changed responsive behaviours for an existing resident. Procedure #3 states that the DOS shall be completed daily as follows: Resident status shall be documented in the appropriate box on 30 minutes intervals over a 24 hour period for a minimum of five days by the PSW staff or designate. The BSO-DOS shall be reviewed for completeness by a registered staff and coloured by the corresponding behaviour observed at the end of each 24 hour period.

Upon review of one resident's responsive behaviour monitoring, the documentation was incomplete. After resident was found wandering in other resident's rooms. A BSO-DOS was initiated, the dates were not properly indicated, and the monitoring was documented for three and a half days instead of five days. In addition, step #3, the analysis and planning of the monitoring documentation on the BSO-DOS worksheet was left blank.

Another BSO-DOS monitoring was initiated for the same resident. The reason for initiating the monitoring, step #1 of the worksheet was left blank. Each day there was several hours left without any entries and step #3 was not completed.

The 24 Hour Safety Check Q 30mins forms for the resident were reviewed for one month. There was no documentation for 65 of the 30 minutes entries,11 shifts and a 24 hour period.

Due to increasing and worsening behaviours of another resident, a BSO-DOS monitoring was initiated. Upon review, it was noted that there was no documentation on two evening shifts out of the five days of monitoring and step #3 was left blank.

Another BSO-DOS was later initiated on this resident and the reason for initiating the monitoring was not documented in step #1 of the worksheet. There were two complete shifts in a row on one day and several hours the next day that had no entries. Step #3 of the form was left blank.

For reasons undocumented, another BSO-DOS was initiated to monitor the same resident. There was no documentation for several hours one day and the next day for an entire shift. Step #3 was left blank.

For worsening and increasing behaviours another BSO-DOS was initiated for the same resident. There was no documentation for two night shifts in a row.

The 24 Hour Safety Check Q 30mins forms were reviewed for this resident and no documentation for 95 of the 30 minutes entries, 28 shifts and 5 periods of 24 hours.

A different resident was experiencing responsive behaviours. After reviewing the resident’s 24 Hour Safety Check Q 30mins forms for 7 days and 37 days at a later time. No documentation was noted for 71 of the 30 minutes entries, 25 shifts and six periods of 24 hours.

One resident’s responsive behaviours caused another resident to fall and they subsequently sustained a head injury. A Neurological Vital Signs Post Head Injury form was initiated to assess resident post head injury. The frequency for the neurological assessments as indicated on the form were as follow: every 15 minutes for the first hour, every hour for three hours and every four hours for the next 20 hours. The last 12 hours of the forms had no entry documented.

One Staff Member confirmed that the last three entries of the Neurological Vital Signs Post Head Injury form initiated should have been recorded. Another Staff Member stated that the PSWs completed step #2 of the BSO-DOS form and did not know what

happened to the forms afterwards. Two Staff Members confirmed the BSO-DOS and the 24 Hour Safety Check Q 30 mins forms were expected and should have been completed.

Sources
Policy Dementia Observation System (DOS) #SM-1.9 Effective July 1, 2013 and last updated September 4, 2019. OMNI HEALTH CARE POLICY/PROGRAM EVALUATION-RESPONSIVE BEHAVIOURS. reporting period: January 2021
Resident's BSO-DOS Behavioural Support Ontario-Dementia Observation System Worksheets. Progress notes, plans of care, Resident Assessment Instrument Medical Data System (Rai-MDS), 24 Hour Safety Check Q 30mins and Neurological Vital Signs Post Head Injury forms.
Interviews with multiple Staff Members.

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 that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care, to be implemented voluntarily.

Issued on this 8th day of February, 2022

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

Original report signed by the inspector.