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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2013	2013_029134_0013	O-000237-13, O-000321-13	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

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

This inspection was conducted on the following date(s): June 12, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), the Life Enrichment Coordinator, Life Enrichment Aid, Nursing Administrative Service Manager, Service Maintenance staff, several Personal Support Workers and several residents.

During the course of the inspection, the inspector(s) toured the unit, observed the medication room, reviewed the staff schedule, observed the lunch dining experience, reviewed the Veterinary Services forms and the licensee's Policy #CP-053 as it relates to Care of Home Dog.

The following Inspection Protocols were used during this inspection:
Medication

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, S.O. 2007, c 8, s.8 (3), in that management failed to ensure that there is a least one registered nurse, who is an employee of the licensee and a member of the regular staff on duty and present at all times.

The nursing staff schedule was reviewed for the period of May 31 to June 13, 2013. There was no Registered Nurse on duty on the night shifts of June 11 and 12, 2013.

Almonte Country Haven is an 82 bed LTC Home. The shifts not being covered by an RN are not a result of an emergency. As such the exceptions to the requirement that at least one RN who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per the O.Reg 79/10s. 45 (1) (1) [s. 8. (3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 130 (2) (i) in that the medication room access was not restricted to persons who may dispense, prescribe or administer drugs in the home.

On June 12, 2013 at approximately 16:00hrs, the Inspector observed the service maintenance staff unlocking the medication room and entering it without being accompanied by a nurse. When interviewed, the maintenance staff member indicated that a spare key was provided several months earlier because a night nurse had locked the key inside the medication room and had to call the maintenance staff member at 2:00hrs to break down the lock in order to retrieve the only key available. The maintenance staff member indicated that a spare medication room key was provided in case this type of incident repeated itself.

As such the medication room is not restricted to persons who may dispense, prescribe or administer drugs. [s. 130. 2.]

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Issued on this 13th day of June, 2013

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

Colette Asselin, Inspector #134