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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2017	2017_627138_0019	031615-16, 035332-16, 000215-17, 002525-17, 002539-17, 008050-17, 008686-17	Critical Incident System

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. BOX250 ALMONTE ON K0A 1A0

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

PAULA MACDONALD (138)

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): June 28 - 29, 2017, and July 4, 2017.

This Critical Incident System inspection included the following:
Log #031615-16, CIS #2962-000021-16, relating to alleged resident abuse,
Log #035332-16, CIS #2692-000024-16, relating to alleged resident neglect,
Log #000215-17, CIS #2692-000001-17, relating to alleged resident abuse,
Log #002525-17, CIS #2692-000008-17, relating to alleged resident abuse,
Log #002539-17, CIS #2692-000009-17, relating to alleged resident abuse,
Log #008050-17, CIS #2692-000013-17, relating to an incident that caused an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,
Log #008686-17, CIS #2692-000015-17, relating to alleged resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nursing Administrative Service Manager, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), a behavioural support Ontario worker (BSO), and the RAI Coordinator.

The inspector also reviewed internal investigation documents, employee training information, employee schedules and work assignments, employee records as it related to this inspection, resident health care records, and a material safety data sheet. The inspector also observed resident to resident interactions as well as staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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	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 comply with section 20.(1) of the Act in that the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents that is in place is complied with.

The home submitted a Critical Incident Report (CIR) to the Director of Ministry of Health and Long Term Care regarding staff to resident abuse. The CIR outlined that PSW #101 observed physical and emotional abuse of resident #003 by PSW #103.

Inspector #138 reviewed the home's internal investigation documents including the signed written witness statement from PSW #101. This witness statement indicated that PSW #101 witnessed physical and emotional abuse of resident #003 by PSW #103 on a specific date, but only reported the incident two days later to management. The inspector spoke with the Administrator regarding the reporting of this incident of abuse and the Administrator confirmed that PSW #101 waited two days after the incident to report the abuse to management.

Inspector #138 reviewed the PSW schedule for the day of the incident and the next day. It was noted that PSW #103, who was witnessed to abuse resident #003, worked again the following day after the abuse was witnessed. The Nursing Administrative Service Manager obtained the PSW assignment sheet for the day after the abuse was witnessed and was able to demonstrate to the inspector that PSW #103 was again assigned to care for resident #003 despite PSW #103 being observed by PSW #101 to abuse the resident the previous day. Once the abuse was reported by PSW #101 two days later, management removed PSW #103 from the schedule, pending investigation.

The Inspector reviewed the home's policy, Zero Tolerance of Abuse and Neglect of

Residents, and noted that the policy directs any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated to immediately report the suspicion to the Director, Home's Administrator, or the manager on call. The policy also states that in the event of an allegation of abuse of a resident the charge nurse, in consultation with the manager on call, will assess the risk and severity of the incident and determine the need to relieve the accused person of their duties pending investigation.

As such, the home's policy, Zero Tolerance of Abuse and Neglect of Residents, was not complied with as PSW #101 did not immediately report the observed physical and emotional abuse of resident #003 by PSW #103. This failure to immediately report prevented the charge nurse from assessing the situation and relieving PSW #103 from duties the day following the witness abuse.

Log # 031615-16 [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 home's written policy to promote zero tolerance of abuse and neglect of residents that is in place is complied with, with respect to the reporting of suspected abuse, to be implemented voluntarily.

Issued on this 7th day of July, 2017

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

Original report signed by the inspector.