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
Nov 2, 2020	2020_770178_0012	011987-20, 017867-20, 018283-20	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

SUSAN LUI (178)

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): October 16, 20-23, 26-28, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #011987-20 was related to falls prevention and management;
Log #017867-20 and Log #018283-20 were related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Assistant Workers (CAWs), and residents.

During the course of the inspection, the inspector observed resident and staff interactions, observed care provided to residents, and resident care areas, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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 ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with when three staff members overheard an alleged incident of staff to resident abuse.

The licensee's Zero Tolerance of Abuse policy indicates that when a staff member witnesses/suspects/hears about an act of abuse or neglect of a resident, they shall immediately after ensuring the resident's safety, report the incident to their direct manager, the Director of Care or the Administrator.

Three staff members overheard an RPN shout at a resident to shut up, and heard the RPN use coarse language in front of the resident. The three staff members all indicated when interviewed that they believed the incident constituted verbal abuse of the resident and should have been reported, but none immediately reported the incident to their direct manager, the DOC or the Administrator. The DOC and Administrator were not in the building at the time, but their phone numbers were available at the nursing station. The direct manager on duty at the time was the RPN who shouted at the resident, but another direct manager started their shift shortly after the incident and none of the three staff members who overheard the incident reported it to the oncoming direct manager. One of the three staff members who overheard the alleged abuse reported it to the Administrator when they returned to work two days later.

Sources:
The Long-Term Care Home (LTCH)'s investigative notes, Zero Tolerance of Abuse policy, interviews with the Administrator and other staff. [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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument after a resident fell.

A resident was found on the floor in their room. The home's fall prevention policy states that whenever a resident falls, a post fall assessment is to be conducted using the Post Fall Investigation assessment instrument. The resident was assessed for injury and sent to hospital, but a post fall assessment was not conducted using the Post Fall Investigation assessment instrument.

Sources:
The Falls Prevention and Falls Management Policy, a resident's clinical health record, interviews with a PSW, an RN and the DOC. [s. 49. (2)]

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 after a resident falls, a post fall assessment is conducted using a clinically appropriate assessment instrument, to be implemented voluntarily.

Issued on this 4th day of November, 2020

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

Original report signed by the inspector.