Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: May 6, 2024
Inspection Number: 2024-1192-0002
Inspection Type: Critical Incident
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Almonte Country Haven, Almonte

Lead Inspector	**Inspector Digital Signature**
Dee Colborne (000721)	Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.05.07 15:53:39 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26, 29, 30, 2024
The inspection occurred offsite on the following date(s): May 1, 2024

The following intake(s) were inspected:

- Intake: #00106269 - Alleged staff to resident neglect
- Intake: #00106277 - Alleged staff to resident neglect

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the written plan of care is complied with. Specifically that a resident's written plan of care is followed by staff.

Rationale and Summary:

Upon review of a resident's written plan of care, on a specified date in April, 2024, it was noted that interventions included to assess resident for tolerance of activity, to be alert to increased confusion, (lethargy) restlessness, irritability, dyspnea, abnormal heart rate and hypoxia and to follow up as needed.

Review of the resident's progress notes identify that the resident was experiencing symptoms as noted on the written plan of care on a specified date in January, 2024 and assessed as such by the Director of Care and then later sent to hospital the same day and later passed away on a specific date in January, 2024.

Review of the homes investigation notes identify that the RN did not assess the resident when first asked to do so by a PSW on a specific day in January, 2024. The PSW attempted to ask the RN to assess three times without success.

During an interview with the PSW on a specified date in April 2024, they confirmed that they had asked the RN several times to assess a resident as they were not felling well before they went to management.

During an interview with Clinical Care Coordinator, they confirmed that a PSW had approached them to report that the RN had not assessed a resident and that they themselves went to start the assessment and reported it to the DOC on a specified date in January 2024.

During an interview with the DOC on a specified date in April 2024, they confirmed that the RN neglected to assess a resident on a specified date in January 2024 and that they themselves went in to assess the resident.

Failure to assess the resident and comply with the written plan of care increases the risk for delaying treatment of the resident.

Sources: Residents written plan of care and progress notes, homes investigation notes, interviews with a PSW, Clinical Care Coordinator and the Director of Care. [000721]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or

neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to ensure that any suspected or alleged abuse/neglect of a resident is immediately reported to the Director. Specifically, the home did not report suspected neglect of a resident by a staff member.

Rationale and Summary:
A Critical Incident report (CI) was submitted by the home to the Director, on a specified date in January 2024 for a suspected incident of neglect towards a resident on a specified date in January 2024, which was seven days after the incident.

Review of the home's investigation notes confirm that neglect towards a resident was substantiated on a specified date in January 2024.

During an Interview with the DOC and Administrator of the home on a specified date in April 2024, both confirmed that the home was late in reporting the neglect of a resident by a staff member.

Failure to immediately report any suspected or alleged neglect to the Director, increases the risk to residents in the delay of appropriate follow up.

Sources: Critical Incident report, homes investigation notes, interviews with the Administrator and DOC.
[000721]

2) The licensee has failed to ensure that any suspected or alleged abuse/neglect of a resident is immediately reported to the Director. Specifically, the home did not

report suspected neglect of a resident by a staff member.

Rationale and Summary:
A Critical Incident report (CI) was submitted by the home to the Director, on a specified date in January 2024 for a suspected incident of neglect towards a resident on a specified date in January 2024, which was seven days after the incident.

Review of the home's investigation notes confirm that neglect towards a resident was substantiated on a specific date in January 2024 and that the Director of Care was aware of the incident that day.

During an interview with a Personal Support Worker (PSW) on a specific date in April 2024, they confirmed they reported the neglect of a resident by the RN, to management of the home on a specified date in January 2024.

During an interview with the Clinical Care Coordinator on a specified date in April 2024, they confirmed they were made aware of the suspected neglect of a resident by a PSW on a specific date and they reported this to the DOC the same day.

During an Interview with the DOC and Administrator of the home on a specified date in April 2024, both confirmed that the home was late in reporting the neglect to the home.

Failure to immediately report any suspected or alleged neglect to the Director, increases the risk to residents in the delay of appropriate follow up.

Sources: Critical Incident Report, homes investigation notes, Interviews with a PSW,

Clinical Care Coordinator, DOC and Administrator.
[000721]

WRITTEN NOTIFICATION: Notifications re: incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

1) The licensee has failed to ensure that a residents substitute decision maker was immediately informed of a suspected incident of neglect that resulted in significant harm to the resident. Specifically, that the home did not contact a resident's substitute decision maker immediately of suspected neglect to the resident.

Rationale and Summary:
Upon review of a resident's progress notes on a specified date in April 2024, the home did not call the residents substitute decision maker until a specified date in January, 2024 to advise them of the suspected resident neglect from a staff member which occurred on a specified date in January 2024. This was 14 days after the day of the incident.

Review of the homes investigation notes on a specified date in April 2024, identify that the home did not call the residents substitute decision maker until a specified

date in January 2024 to advise them of the suspected resident neglect from a staff member which occurred on a specific date in January 2024.

Interview with the DOC and Administrator on a specified date in April 2024 confirmed that the home did not advise a resident's substitute decision maker about the suspected neglect until a specified date in January 2024.

Failure to immediately inform a resident's substitute decision maker of suspected neglect in a timely manner, delays their involvement in the plan of care.

Sources: Resident's progress notes, homes investigation notes, interviews with the Administrator and DOC.
[000721]

2) The licensee has failed to ensure that a residents substitute decision maker was immediately informed of a suspected incident of neglect that resulted in significant harm to the resident. Specifically, that the home did not contact a second resident's substitute decision maker immediately of suspected neglect to the resident.

Rationale and Summary:
Upon review of a second resident's progress notes on a specified date in April 2024, the home did not call the residents substitute decision maker until a specified date in January 2024 to advise them of the suspected resident neglect from a staff member which occurred on a specified date in January 2024. This was 14 days after the day of the incident.

Review of the homes investigation notes on a specified date in April 2024, identify that the home did not call the residents substitute decision maker until a specified date in January 2024 to advise them of the suspected resident neglect from a staff

member which occurred on a specified date in January 2024.

Interview with the DOC and Administrator on a specified date in April 2024, confirmed that the home did not advise the resident 's substitute decision maker about the suspected neglect until a specified date in January 2024.

Failure to immediately inform a resident's substitute decision maker of suspected neglect in a timely manner, delays their involvement in the plan of care.

Sources: Resident's progress notes, homes investigation notes, interviews with the Administrator and DOC.
[000721]