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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2015	2015_284545_0020	O-002438-15	Critical Incident System

Licensee/Titulaire de permis

ALMONTE GENERAL HOSPITAL
75 SPRING STREET ALMONTE ON K0A 1A0

Long-Term Care Home/Foyer de soins de longue durée

FAIRVIEW MANOR
75 SPRING STREET ALMONTE ON K0A 1A0

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

ANGELE ALBERT-RITCHIE (545)

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): August 28, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC),a Registered Practical Nurses (RPN) and several Personal Support Workers (PSW).

The inspector also reviewed the home's policies and procedures on Prevention of Abuse/Neglect and Responsive Behaviours, staff schedule, investigation report, residents' health records including, Plans of Care and other documentation within the home, toured residential areas, and observed resident care provision and services, including interaction between staff and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. 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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately report the suspicion and the information upon which it is based to the Director.

In a review of the Critical Incident Report (CIR) submitted by the home on a specific date in September 2014, the Director of Care documented that two days before - Resident #001 was found with his/her hand up the front of Resident #002's shirt. It was noted that both Residents were separated, and that Resident #002 was taken to a nearby room to calm and comfort as appeared to be teary.

In a review of a progress note dated a specific date in September 2014, it was documented that Resident #001 was found with his/her hand up Resident #002's shirt grabbing his/her and that once the PSW removed Resident #002's grip on Resident #001, PSW took Resident #002 into a room to console him/her, as he/she was upset and agitated.

During an interview with the Director of Care (DOC) on August 28, 2015, she indicated she was out of the building at the time the Resident to Resident sexual abuse occurred. The DOC indicated that she was immediately notified of the incident. The DOC who had reasonable grounds to suspect sexual abuse of Resident #002 by Resident #001 that resulted in harm or a risk of harm to the resident, indicated that she did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (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 a person who has reasonable grounds to suspect abuse of a resident by anyone that result in harm or a risk of harm to the resident immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of an abuse of a resident by anyone that is reported is immediately investigated.

In a review of the Critical Incident Report (CIR) submitted by the home on a specific date in September 2014, the Director of Care documented that two days before - Resident #001 was found with his/her hand up the front of Resident #002's shirt. It was noted that both Residents were separated, and that Resident #002 was taken to a nearby room to calm and comfort as appeared to be teary.

In a review of a progress note dated a specific date in September 2014, it was documented that Resident #001 was found with his/her hand up Resident #002's shirt grabbing him/her and that once the PSW removed Resident #002's grip on Resident #001, PSW took Resident #002 into a room to console him/her, as he/she was upset and agitated. The note further indicated that a Patient Risk Incident Management System (PRIMS) report had been completed and sent to the DOC.

During an interview with the Director of Care (DOC) on August 28, 2015, she indicated she was out of the building at the time the Resident to Resident sexual abuse occurred. The DOC indicated that she was immediately notified of the incident. The DOC further indicated that she did not initiate the investigation until two days after the incident. [s. 23. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

In a review of the Critical Incident Report (CIR) submitted by the home on a specific date in September 2014, the Director of Care documented that 2 days before - Resident #001 was found with his/her hand up the front of Resident #002's shirt. It was noted that both Residents were separated, and that Resident #002 was taken to a nearby room to calm and comfort as appeared to be teary.

The DOC indicated during an interview on August 28, 2015, that when she was notified of an alleged incident of abuse of a Resident by Resident #001 on a specific date in September 2014, she did not ensure that the appropriate police force was immediately notified. [s. 98.]

Issued on this 17th day of September, 2015

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

Original report signed by the inspector.