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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 20, 2018	2018_627138_0006	022618-18, 026315-18, 028479-18	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

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): November 13, 14, and 15, 2018.

The following Critical Incident System intakes, all related to alleged resident abuse, were inspected during this Critical Incident System Inspection:
Log #022618-18, CIS #2973000030-18;
Log #026315-18, CIS #2973-000034-18 and;
Log #028479-18, CIS #2073-000036-18.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Care, the Assistant Director of Care, personal support workers, practical registered nurses, a Behavioural Support Ontario Champion, a Registered Nurse from the Geriatric Psychiatry Outreach Program with Lanark County Mental Health, a Behavioural Support Ontario/Registered Nurse with the Royal Ottawa Hospital and Lanark County Mental Health, and a Behavioural Therapist from the Royal Ottawa Hospital.

The inspector also reviewed a resident health care record and observed a resident on a home area including during a meal service.

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.
1 WN(s)
0 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. 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 shall immediately report the suspicion and the information upon which it is based the Director.

The Director of Care of the home received information in August 2018, alleging that resident #001 was abused, however, the Director was not notified until eight days of the alleged abuse.

A critical incident report was reviewed and it was noted to be submitted to the Director by the Director of Care outlining that the Director of Care had received a verbal report eight days prior of alleged abuse to resident #001. The Director of Care was interviewed and the Director of Care stated that a verbal report of alleged abuse to resident #001 was received in August 2018, and that an investigation was immediately undertaken. The Director of Care stated that the Director was notified of the alleged abuse via the critical incident report submitted eight days later.

As such, the alleged abuse of resident #001 reported to the Director on Care in August 2018, was not immediately reported to the Director.

(Log 022618-18) [s. 24. (1)]

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.