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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Apr 25, 2019	2019_593573_0009	003771-19, 004073-19	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

ANANDRAJ NATARAJAN (573)

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): March 26 -29, 2019, April 1 and 2, 2019.

The following intakes were completed during this Critical Incident System inspection:
Log #003771-19 related to alleged staff to resident emotional abuse.
Log #004073-19 related to alleged resident to resident physical abuse

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

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, reviewed residents health record, home's internal investigation documentation, as applicable and licensee policy related to the prevention of resident abuse and neglect.

In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions

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.
- **2 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	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 that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident alleged emotional abuse incident.

During an interview with Inspector #573 on April 02, 2019, PSW #102 indicated that they observed PSW #105 on more than one occasion, cover two residents face/ head with blanket and laugh after completing the care. Furthermore, PSW #102 indicated that they did not report this incident to the MOHLTC or the management immediately. PSW #102 indicated awareness that the incident should have been reported right away to their supervisor or the MOHLTC.

On April 02, 2019, Inspector #573 spoke with the DOC, who indicated that on a specified date, PSW #102 reported allegation of PSW #105 to resident's emotional abuse incidents. The DOC indicated to the inspector that an investigation was initiated immediately and the investigation confirmed that staff to resident emotional abuse occurred. Furthermore, the DOC indicated to Inspector #573 that the alleged staff to resident emotional abuse incident had not been reported immediately to the MOHLTC Director until a specified date, when the CIR was submitted.

As such, the licensee has failed to ensure that the persons who had reasonable grounds to suspect that abuse of a resident by anyone occurred, did immediately report the suspicion and the information upon which it was based to the Director. (Log #003771-19) [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 the person who has reasonable grounds to suspect that abuse of a resident by anyone occurred, does immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act (LTCHA), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

On April 02, 2019, Inspector #573 reviewed the licensee's policy titled Abuse and Neglect of a Patient/ Resident, the policy indicates that the original date was January 2007 and the policy revised date was November 28, 2013.

Interview between Inspector #573 and the DOC on April 02, 2019, indicated that the home's policy to promote zero tolerance of abuse and neglect of residents is not evaluated for the effectiveness annually. Furthermore, the DOC indicated that the licensee's policy to promote zero tolerance of abuse and neglect of residents last revised/ evaluated date was on November 28, 2013. (Log #003771-19) [s. 99. (b)]

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.