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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 14, 2022
Inspection Number 2022_1456_0001
Inspection Type

☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ________________

Licensee
Almonte General Hospital
75 Spring Street Almonte ON K0A 1A0

Long-Term Care Home and City
Fairview Manor
75 Spring Street Almonte ON K0A 1A0

Lead Inspector
ANANDRAJ (ANDY) NATARAJAN #573

Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30, 31, 2022, June 1, 2, 6, 7 and 8, 2022.

The following intake(s) were inspected:

- Intake 000338-22 complaint related to allegation of staff to resident physical abuse.
- Intake 009839-22 complaint related to missing and damaged resident’s clothing

Inspector(s) #740811 and 740814 were present throughout the inspection as an observer.

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

- Prevention of Abuse and Neglect
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 [s.102. (8)]

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program, in relation to Personal Protective Equipment.

Rationale and Summary: The inspector observed three resident rooms on a specified unit with contact precautions signage posted outside their room with no isolation carts containing Personal Protective Equipment. An interview with the RPN on the unit confirmed that the identified three residents were on contact precautions. Inspector spoke with the Infection Prevention and Control (IPAC) program lead regarding the observations on the unit. The following day, the inspector observed that isolation carts containing Personal Protective Equipment were placed outside the identified three resident rooms.

Sources: Inspector observations, interview with the RPN and the IPAC lead.

Date Remedy Implemented: June 2, 2022 [#573]