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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 2, 2024	
Inspection Number: 2024-1456-0001	
Inspection Type: Critical Incident	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Dee Colborne (000721)	**Inspector Digital Signature** Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.02.15 14:01:01 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 17, 18, 2024

The following intake(s) were inspected:

- Intake: #00100560 - Alleged physical abuse to resident by a visitor.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Written Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve;

(c) clear directions to staff and others who provide direct care to the resident; and

(d) any other requirements provided for in the regulations.

The licensee has failed to ensure that there is a written plan of care outlining the planned care for the resident, the goals the plan is attended to achieve, clear directions to staff and others who provide care to the resident and any other requirements provided for in the regulations. Specifically, there was no written plan of care for resident #001, to keep them safe from alleged abuse of a family member when visiting in the home.

Rationale and Summary:

Resident #001's written plan of care, had nothing noted in regards to interventions and team discussions in keeping the resident safe from harm after an incident of resident #001 reporting alleged abuse by a family member on a specified date in October 2023.

Resident #001's progress notes, that frontline PSW's do not have access to, identify that directions were given to staff to monitor visits of resident and family member by

ensuring the room door and the curtain in the room was kept open and to monitor the visit frequently.
Resident #001's kardex was reviewed and there were no intervention or directions in ensuring the door to the room and curtain to bedroom was to be kept open and to ensure frequent monitoring when family member was visiting.

Interview with a PSW confirmed that they were aware to ensure when family was visiting a resident to ensure the curtain in room was to be kept open and to do frequent monitoring. They confirmed this would be found on the resident kardex.
Interview with an RN confirmed there were many discussions in regards to how to keep resident #001 safe and whether in house monitoring needed to be occurring and if resident would be allowed to leave. They stated that this information was only passed on in the shift report and was not able to confirm if it was documented in the resident #001's written plan of care.
Interview with DOC confirmed that the interventions put in place to keep resident #001 safe from harm, was not in the resident #001's written plan of care.

Failure to ensure there is a written plan of care for a resident in regards to keeping them safe, increases the risk of staff not being aware of the interventions put in place to keep the resident safe from harm.

Sources: Resident #001's progress notes, care plan and kardex, interview with DOC and other staff.
[000721]

WRITTEN NOTIFICATION: Licensee must investigate alleged abuse

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act
s. 27 (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,

The licensee has failed to ensure that when a report of alleged abuse of a resident by anyone occurs, that it is immediately investigated by the home. Specifically, an incident of alleged abuse was reported to the home by resident #001 and the home did not conduct an investigation into the matter immediately.

Rationale and Summary:
Progress notes of resident #001 identified that they reported being physically abused by their family member while out on an outing on a specified date in October 2023. Resident #001 reported the incident to staff on a specified date in October 2023. Further notes identify that the home called the Ontario Provincial Police (OPP) who came into see resident #001 and conducted an interview on a specified date in October 2023. The OPP advised staff they would be continuing with an investigation and will calling staff who the alleged abuse was reported to.

Review of the home's investigation notes states that in a follow up call from OPP after their visit, the home was advised to not tell the accused family member who was one of the Substitute Decision Maker's (SDM) for the resident, of the OPP's visit, but there is no date as to when this follow up call occurred. There is no mention stating that the home couldn't conduct their own investigation.

Interview with the Director of Care (DOC) confirmed that the home did not investigate immediately. The DOC confirmed they felt their hands were tied as they were advised by the OPP to not tell the SDM that an OPP investigation was

occurring. The DOC confirmed they are aware of the legislation to investigate alleged abuse immediately.

Failure to investigate alleged physical abuse of a resident immediately, increases the risk of appropriate care and interventions being implemented to keep the resident safe from physical harm.

Sources: Resident #001's progress notes, homes investigation notes, interview with DOC.

[000721]

WRITTEN NOTIFICATION: Notification of 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

The licensee has failed to ensure that the substitute decision maker (SDM) has been immediately notified of an alleged abuse of a resident that has resulted in physical injury or harm. Specifically, that resident #001's emergency contact #2 (SDM) was not notified of alleged abuse that caused physical harm to resident #001.

Rationale and Summary:

Progress notes of resident #001 identified that they reported being physically abused by their family member who has POA, while out on an outing on a specified date in October 2023. Resident #001 reported the incident to staff on a specified date in October 2023. It was further noted that resident #001's SDM, called the home on a specified date in October 2023 to enquire as to why resident #001 had noted injuries to a specific part of their body. The SDM was told that it occurred while out on an outing with the family member.

Review of the home's investigation notes state the home was advised to not tell the accused family member of the OPP's visit. There is no mention to not discuss with other SDM's. Further notes state that there was evidence of injuries. A meeting with both SDM's occurred on a specified date in November, 2023 which was a considerable number of days after the incident occurred to discuss the circumstances and concerns in the SDM taking the resident out of the home.

Review of head to toe assessment conducted on a specified date in October 2023 identified 17 areas of impaired skin integrity.

Review of the homes policy on "Abuse and Neglect of a Patient/Resident -Actual or suspected" last reviewed on March 23, 2023 identifies that a residents SDM or any other person identified by a resident is to be notified immediately of the alleged abuse if it resulted in physical injury.

Interview with the DOC confirmed that at the time of the reported alleged abuse the home did not call the SDM but that the SDM was advised when they called on a specified date in October 2023 looking for answers. They did meet with both SDM's on a specified date in November 2023 as the accused family member wanted to take resident #001 home for the holidays and the home felt this was the time to advise them of calling the OPP. The DOC confirmed there has still been no direction or update from the OPP.

Failure to immediately notify the SDM of alleged physical abuse of a resident, may increase the risk for the detriment of the residents health and well being.

Sources: Resident #001 progress notes, homes investigation notes, homes policy on Abuse and Neglect of a Patient/Resident -Actual or suspected; interview with DOC and other staff.
[000721]

WRITTEN NOTIFICATION: Staff training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that direct care staff who provide care to residents, receive training on abuse recognition and prevention, on an annual basis. Specifically, a Personal Support Worker, and a Registered Nurse were not provided training on mandatory abuse and neglect for the year 2023. The RN was also not provided with training on reporting requirements to the Ministry for the year 2023.

Rationale and Summary:
Training records for both PSW and RN staff were reviewed on a specified date in January 2024 for the year 2023. It was noted that both the PSW and RN did not receive training on abuse and neglect prevention for the year 2023. It was further noted that the RN did not receive any training on reporting requirements to the

Director for the year 2023.

Interview with the PSW confirmed that they have not had any training on abuse and neglect.
Interview with the RN confirmed that they have not had any training on abuse and neglect in approximately 2 years.
Interview with DOC confirmed that the PSW and RN have not had any training on Abuse and neglect for 2023 and that the RN has not had any training on reporting requirements to the Director for 2023.

Failure to provide annual training on abuse and neglect and reporting requirements, for staff that are providing direct care to the residents increases the risk of maintaining resident safety and increases the risk for incidents of abuse or neglect not being investigated in a timely manner.

Sources: Training records for PSW and RN, Interviews with PSW , RN and the DOC.

[000721]

COMPLIANCE ORDER CO #001 Directives by Minister

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (c)]:
The licensee shall:

a. Perform audits to ensure all staff, specifically on identified staff, three times a week for four weeks to ensure that they are following masking requirements as directed while on resident units.
b. Document the audits and corrective actions taken based on audit results.

A written record must be kept of everything required under steps (a), and (b) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023, when masking requirements were not followed by staff.

Rationale and Summary:
In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023; licensees are required to ensure that the masking requirements as set out in this guidance document are followed. As one of the key defenses against the transmission of respiratory viruses, homes must ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times. Masks are required to be worn in all resident areas indoors.

On a specified date in January 2024, during the inspectors' tour of the home,

inspector noted at a specified time, a Recreation Therapist in the activity room on a specified unit, with their mask down under their chin and reading from a book to a group of residents in front of them.
On a specified date in January 2024, at a specified time, inspector noted a PSW without a mask on sitting at the nursing station.
On specified date in January 2024, at a specified time, inspector noted an RPN sitting at the nursing station with their mask down under their chin.
On specified date in January 2024, at a specified time, inspector noted an RN at the nursing station on a specified unit, as inspector was walking past, with their mask down under their chin sitting with another staff member. Inspector came by again at another specified time and the RN still had their mask down under their chin. The RN was later seen by inspector at another specified time sitting at nursing station desk, working at a computer with their mask under their chin.
On a specified date in January 2024, at a specified time, inspector noted a PSW in front of the nursing station at a specified time, on their cell phone with their mask under their chin. A resident was sitting near by them within approximately three feet.

Interview with IPAC lead #104 confirmed that all staff are to wear masks when on resident clinical areas including nursing stations.
Interview with the DOC confirmed all staff should be wearing their masks in resident areas.

Failure to comply with the masking requirements for masks to be worn on all resident areas indoors, places the residents at risk of transmission of infectious diseases.

Sources: Inspector #000721 observations, interviews with IPAC Lead #104, an RN and other staff
[000721]

This order must be complied with by March 19, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.