Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: July 3, 2024	
Inspection Number: 2024-1456-0004	
Inspection Type: Critical Incident	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Margaret Beamish (000723)	Inspector Digital Signature
Additional Inspector(s) Jessica Lapensee (133)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14, 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00115034 was a reported critical incident about flooding in a dining room.

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the licensee's falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:
The licensee's falls prevention and management policy indicated that the last revision date was April 2019. Interview with the Assistant Director of Care (ADOC) confirmed that the policy was last revised/evaluated in April 2019, and there was no review done in 2023.

As such, there is potential risk to resident safety by the falls prevention and management program not being evaluated and updated at least annually.

Sources: policy titled Fall Prevention and Management (V11-G-60.00) last reviewed April 2019, and interview with ADOC. [000723]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (b)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the licensee's responsive behaviours program was evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.

Rationale and Summary:
The licensee's responsive behaviours policies indicated that the last revision dates were April 2019. Interview with the Assistant Director of Care (ADOC) confirmed that the policies were last revised/evaluated in April 2019, and there was no review done in 2023.

As such, there is potential risk to resident safety by the responsive behaviours program not being evaluated and updated at least annually.

Sources: policies titled Responsive Behaviours (V11-F-30.00) last reviewed April 2019, Responsive Behaviours - Guidelines for High Risk (V11-F-30.00(c)) last reviewed April 2019, and interview with ADOC. [000723]

WRITTEN NOTIFICATION: Evaluation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 122 (b)
Evaluation
s. 122. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 33 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;

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 minimize restraining of residents.

Rationale and Summary:
The licensee's policy to minimize restraining of residents indicated that the last revision date was April 2019. Interview with the Assistant Director of Care (ADOC) confirmed that the policy was last revised/evaluated in April 2019, and there was no review done in 2023.

As such, there is potential risk to resident safety by the licensee's policy to minimize restraining of residents not being evaluated to determine its effectiveness at least once in every calendar year.

Sources: policy titled Restraint Management Protocols (V11-F-10.08) last reviewed April 2019, and interview with ADOC. [000723]

COMPLIANCE ORDER CO #001 Training and orientation program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 257 (1)
Training and orientation program
s. 257 (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 82 and 83 of the Act.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Develop a program that provides for the required orientation training in all areas listed in FLTCA, 2021, s. 82 (2) and O. Reg. 246/22, s. 259 (1).

B) Develop an implementation plan that will guide the delivery of the required training.

C) Provide three specified PSWs and all other staff in the home with the required training. Keep records and dates of this training including the name, position and department of each staff member that receives training, what training was provided and when, who provided the training (if applicable).

D) Provide a specified staff member with the required training including a focus on all areas of the FLTCA, 2021 and O. Reg. 246/22 that refer to the role of an Administrator and all policies of the licensee that include a role for the Administrator. Keep records, dates and details of this training.

A written record must be kept of everything required under (A), (B), (C) and (D) until the Ministry of Long-Term Care has determined the licensee has complied with this

order.

Grounds
The licensee has failed to ensure that a training and orientation program for the home was developed and implemented to provide the orientation under section 82 of the Act.

Rationale and Summary:
On a specified date, the new CEO of the Mississippi River Health Alliance (MRHA) explained that their duties encompassed the Administrator role at Fairview Manor. The CEO confirmed that they had not been provided with orientation training as stipulated by section 82 (2) of the Fixing Long-Term Care Home Act, 2021 (FLTCA, 2021) before commencing their responsibilities on a specified date.

On a specified date, the home's Assistant Director of Care (aDOC) confirmed that they were working to review and update the orientation program to bring it into line with the requirements prescribed under FLTCA, 2021, s. 82(2) and the regulation (O. Reg. 246/22). The aDOC explained that responsibility for the orientation program was being transferred from the Integrated Education Coordinator (IEC) to them.

On a specified date, the IEC explained that their responsibilities extended beyond the home to encompass the MRHA organization. Regarding new staff at the home, the IEC's role was to assign Surge Learning courses. The IEC confirmed that all of the home's staff received the same courses, from a predetermined group. Surge Learning Education Status Reports were provided for three specified PSWs as they were the most recent new staff to start working at the home. The IEC clarified that CEO was assigned courses from a different group, for senior leaders in the MRHA organization, that afternoon. The IEC indicated that they were unaware of the specific courses in the groups they assigned and that their involvement was limited

to assigning the courses.

The review of Surge Learning Education Status Reports for three specified PSWs revealed that among the areas mandated by FLTCA, 2021, section 82 (2), only the Resident Bill of Rights was included in the courses assigned by IEC. As of a specified date, two of the PSWs had not completed the Resident's Bill of Rights course. The deadline for this course had been set for a date after they had started working, hence it had not been mandatory for the PSWs to finish it before starting their duties. Additionally, one of those PSWs had not finished any of their assigned Surge Learning courses. The aDOC indicated they had been under the impression that new staff would not be allowed to begin work until completion of their assigned Surge Learning courses had been confirmed, a task they had believed was managed by the organization's Human Resources department.

The review of the Surge Learning Education Status Report for the CEO revealed that none of the areas mandated by FLTCA, section 82 (2) was included in the courses assigned by the IEC.

On a specified date, the aDOC described a new process they had implemented whereby they met with new staff to orient them to the care units, followed by an introduction to six specified policies. These policies were then emailed to the new staff, who were instructed to review and electronically sign them before starting their work. On a specified date, the aDOC confirmed that this process had been completed with two of the PSWs but not with one of the PSWs.

Of the six policies being provided to new staff by the aDOC, two were applicable to the requirements of section 82 (2) of the Act. One related to section 82 (2) 3, the policy to promote zero tolerance of abuse and neglect of residents, and the other related to section 82 (2) 6, the long-term care home's policy to minimize the

restraining of residents. Upon review, it was noted that the policy "Restraint Management Protocols (VII-F-10.08)" with a last review date of April 2019 had been provided without it's appendices. The policy is the subject of non-compliance #003 within this inspection report. Upon review, it was determined that the aDOC had been mistakenly providing the home's outdated policy to promote zero tolerance of abuse and neglect of residents, titled "Abuse and Neglect of a Patient/Resident: Actual or Suspected (VII-G-10.00)" with a last reviewed date of May 2019. Related to the duty under section 28 of the Act to make mandatory reports, and protections afforded by sections 30 of the Act, the aDOC explained that as of a specified date, they began to assign training in these two areas to the Registered Nurses of the home. The aDOC confirmed they were aware that such training was required for all staff in the home.

On a specified date, the IPAC lead reviewed the process they followed with new staff and it was confirmed that the process provided for orientation training in IPAC as per s. 82 (2) 9. This was the only area of section 82 (2) of the Act that the orientation training program complied with.

In summary, the home did not have an orientation training program developed and implemented to provide the orientation required under section 82 of the Act. Specifically, the orientation training program did not provide for: The Residents' Bill of Rights; The long-term care home's mission statement; The duty under section 28 to make mandatory reports; The protections afforded by section 30; The long-term care home's policy to minimize the restraining of residents; Fire prevention and safety; Emergency and evacuation procedures; All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and the following areas provided for in section 259 (1) of O. Reg. 246/22: The licensee's written procedures for handling complaints and the role of staff in dealing with complaints; Safe and correct use of equipment,

including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities; cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

The impact of staff not being provided the required orientation training, prior to performing their responsibilities, placed residents at risk.

Sources: Interviews with the President and Chief Executive Officer of the Mississippi River Health Alliance (CEO), the Assistant Director of Care, the Integrated Human Resources Manager, the Integrated Education Coordinator, the IPAC Lead. Review of the Surge Learning Education Status Report – 2024 for the CEO and for three PSWs. Review of the home's policy "Abuse and Neglect of a Patient/Resident: Actual or Suspected (VII-G-10.00)" with a last reviewed date of May 2019, and "Restraint Management Protocols (VII-F-10.08)" with a last review date of April 2019. [133]

This order must be complied with by September 30, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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.