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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2013	2013_200148_0027	O-000492-13	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

AMANDA NIXON (148)

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): July 18 and 22, 2013, on site.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Human Resource Representative, Registered Nursing Staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, the home's policy entitled Abuse or Suspected Abuse of a Resident along with incident reporting policies, the home's investigation data related to the incidents involving Staff member #101, education records for identified staff members and nursing staff schedules. In addition, Critical Incident reports, as submitted to the Director were reviewed and resident care was observed on the Maple Grove unit.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not comply with LTCHA 2007, S.O., 2007, c.8, s.20(2) (b) and (d), in that the licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect and contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Policy # VI-G-10.00 entitled Abuse or Suspected Abuse of a Resident was provided to the Inspector by the DOC upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy does not clearly set out what constitutes abuse and neglect in that:
- the policy does not define sexual abuse or verbal abuse.
- the definition of physical abuse does not clearly set out that physical abuse includes physical force by anyone, does not include the administering or withholding of a drug for an inappropriate purpose and provides no distinction between resident to resident physical abuse and physical abuse by anyone, as defined by O.Reg 79/10, 2(1).
- the definition of emotional abuse does not include gestures, actions, behaviours or remarks and provides no distinction between resident to resident emotional abuse and emotional abuse by anyone, as defined by O.Reg 79/10, 2(1).
- the definition of neglect does not include the failure to provide treatment, care or assistance and does not include inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents, as defined by O.Reg 79/10, 5.

A review of the Abuse policy demonstrates that the policy does not include an explanation of the duty under Section 24 of the Act, in that a person who has reasonable grounds to suspect that 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 shall be immediately reported to the Director.

Findings related to LTCHA 2007, s.76 (4) (WN#3)and LTCHA 2007, s.24(1)2. (WN #6), further support the additional required action of a Compliance Order. [s. 20. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.96 (b), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

Policy # VI-G-10.00 entitled Abuse or Suspected Abuse of a Resident was provided to the inspector by the DOC upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy contains procedures and interventions to deal only with staff members who have been found guilty of abuse and staff members who pose imminent threat. The policy does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

The licensee failed to comply with O.Reg 79/10, s.96 (c), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

A review of the Abuse policy demonstrates that the policy does not identify measures and strategies to prevent abuse and neglect.

The licensee failed to comply with O.Reg 79/10, s.96 (e), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii. situations that may lead to abuse and neglect and how to avoid such situations.

A review of the Abuse policy demonstrates that the policy does not identify the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii. situations that may lead to abuse and neglect and how to avoid such situations.

Findings under LTCHA 2007, s.76(4) (WN#3) and LTCHA 2007, s.23 (1)(b) (WN#5)

1. The licensee failed to comply with O.Reg 79/10, s.96 (b), in that the licensee did not

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.76 (4), in that the licensee did not ensure that persons who have received training under s.76 (2) of the Act receive retraining in the areas mentioned in that section, at annual intervals, as indicated by O.Reg 79/10, s.219 (1).

As per LTCHA 2007, S.O. 2007, c.8, s.76 (1), all staff at the home are to receive training as required by Section 76 of the Act.

As per LTCHA 2007, S.O. 2007, c.8, s.76 (2) 4. and 5., training is to be provided in the areas including, the duty under Section 24 of the Act to make mandatory reports and the protections afforded by Section 26 of the Act.

Upon request by the Inspector, the home's DOC could not demonstrate that the training of staff at the home, at annual intervals, included the duty under Section 24 of the Act, related to mandatory reporting and the protections afforded under Section 26 of the Act, related to whistle blowing. [s. 76. (4)]

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 all staff at the home receive training at annual intervals that include the duty under Section 24 of the Act and the protections afforded by Section 26 of the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (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
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.97 (1) (b), in that the licensee did not ensure that the resident's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

1. The home's DOC reported to the Inspector that on a specified date, Staff member #101 was witnessed by Staff member #111 to be providing inappropriate continence care to Resident #7. The incident was brought to the DOC's attention on the same date. The DOC reported to the Inspector that it was on this date in which she suspected abuse may have occurred. The DOC confirmed that the SDM had not been notified as of the time of this inspection.

2. As per a Critical Incident report, statements from the home's DOC and the home's investigation data, information came forward to the Assistant Director of Care on a specified date that indicated concerns with the care provided to resident's by Staff member #101. Initial concerns brought forward included inappropriate provision of care related to Resident #1, #2 and #3, on a specified date. The incidents were brought forward to the home's DOC four days after the incidents occurred at which time an investigation was initiated into the suspected abuse. The DOC confirmed that the SDM's for Resident #1, #2 and #3 were not informed of the alleged abuse until approximately 2 months after the incidents occurred, when the home's investigation into the incident was completed. [s. 97. (1) (b)]

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 resident's SDM is notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (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,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.23 (1)(b), in that the licensee did not ensure that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

On a specified date, the home's DOC became aware of suspected abuse that had occurred on a specified date on a specified unit, involving Staff member #101. In response, the determined appropriate action was to monitor Staff member #101 and conduct an investigation into the incidents.

Related to the monitoring of Staff member #101, the DOC informed Staff member #107 along with the day and evening charge nurses, that concerns were brought forward related to the care provided by Staff member #101 and that an investigation was ongoing. The home's DOC reported to the Inspector that instruction was given to Staff member #107 to monitor the care provided by Staff member #101. In addition, the DOC indicated that she increased walkabouts and assisted in monitoring the Unit.

An interview with Staff member #107 confirmed that he/she had been notified of the concerns brought forward with the provision of care related to Staff member #101 and that the care provided by Staff member #101 was to be monitored. Further to this, Staff member #107 reported to the Inspector that due to the work routine, was only able to observed care in passing, as he/she is not present in resident rooms when care is being provided nor are the halls of the unit viewable from the nursing station where he/she is usually located. Upon further questioning, Staff member #107 disclosed that, prior to April 2013, Staff member #101 was known to use a raised voice with residents, some instances of which required Staff member #107 to intervene; Staff member #107 reported that this was not reported to the supervisory staff. Staff member #107 further reported that he/she had observed Staff member #101 to be rough with Resident #6 while providing care; Staff member #107 did not report the incident to supervisory staff nor did he/she intervene at the time of the incident. In addition, Staff member #107 indicated that prior to the home's investigation into the alleged abuse incidents, he/she had been approached by co-workers on the unit who reported concerns about the care provided by Staff member #101; Staff member #107 did not report these concerns to the supervisory staff.

Staff member #101 provided care on the unit on several identified dates after the home initiated an investigation into the alleged abuse incidents. With the exception of one shift, the immediate supervisory staff was aware of the ongoing investigation,

concerns with provision of care related to Staff member #101 and the instruction to monitor the provision of care. During a shift on one of the identified dates, Staff member #103 witnessed Resident #4 to be improperly restrained by Staff member #101. The incident was reported to the home's DOC on the same date.

Staff member #101 provided care on the unit on several identified dates. As reported by the DOC, the immediate supervisory staff members working on the unit during two of the identified dates were not made aware by the DOC, of the concerns related to the provision of care, nor were they instructed to monitor Staff member #101.

The appropriate action taken to respond to the suspected abuse, as indicated by the home's DOC, was for the supervisory staff members on the unit and the DOC to monitor the provision of care provided by Staff member #101. Staff member #107, a supervisory staff member, reported that monitoring could only be done in passing and not during all direct care of residents. A subsequent incident of abuse related to the restraining of a resident occurred on a specified date while the monitoring program was in place. After the subsequent incident the home continued with the initial monitoring program for Staff member #101. In addition, two shifts were identified in which Staff member #101 provided care to residents without the supervisory staff members having direction to monitor the care provided by Staff member #101.

Note, LTCHA 2007, s.23 (1)(b), is referenced as part of the findings supporting Compliance Order #002. [s. 23. (1) (b)]

WN #6: 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 did not comply with LTCHA 2007, S.O. 2007, c.8, s.24 (1) 2., in that the licensee did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

1. As per a Critical Incident (CI) report, Staff member #112 was witnessed by Staff member #113, on a specified date to use inappropriate language toward Resident #9, causing the resident to react negatively during care. The DOC was informed of the incident 2 days later and an investigation commenced and concluded that verbal abuse had occurred.

The incident was not immediately reported to the Director.

2. The home's DOC reported to the Inspector that on a specified date, Staff member #101 was witnessed by Staff member #111 to be providing inappropriate continence care to Resident #7. The incident was brought to the DOC's attention on the same date. The DOC reported to the Inspector that it was on this date in which abuse was suspected may have occurred.

The incident has not been reported to the Director as of the time of this inspection.

3. As per a Critical Incident report, statements from the home's DOC and the home's investigation data, information came forward to the Assistant Director of Care on a specified date that indicated concerns with the care provided to resident's by Staff member #101. Initial concerns brought forward included inappropriate provision of care related to Resident #1, #2 and #3 on a specified date. The incidents were brought forward to the home's DOC four days after the incidents occurred at which time the DOC had grounds to suspect abuse and an investigation was initiated into the suspected abuse.

During the investigation several other incidents were reported by co-workers that involved the provision of care to residents by Staff member #101, including 5 other dates. Upon the completion of the home's investigation it was found that abuse had occurred.

The incident's were not immediately reported to the Director.

4. Staff member #107 reported to the Inspector that, prior to the home's investigation into the alleged abuse incidents, Staff member #101 was known to raise his/her voice with residents, some instances of which required Staff member #107 to intervene. Staff member #107 further reported that he/she had observed Staff member #101 to be rough with Resident #6 while providing care. In addition, Staff member #107 indicated that prior to the home's investigation, he/she had been approached by co-workers on the unit who reported concerns about the care provided by Staff member #101. Staff member #107 did not report these concerns to the supervisory staff nor to the Director.

This inspection identified several incidents in which the Director was not immediately notified of reasonable grounds to suspect that abuse of a resident had occurred.

Note, LTCHA 2007, s.24(1)2., is referenced as part of the findings supporting Compliance Order #001. [s. 24. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 30(1)2., in that the licensee did not ensure that a resident is not restrained as a disciplinary measure.

On a specified date Staff member #103 witnessed Resident #4 to be improperly restrained, while Staff member #101 sat near by. When questioned by Staff member #103, Staff member #101 indicated that the resident was restrained so that the resident will remember to use a walker. After approximately 20 minutes, Staff member #101 approached Resident #4 saying now you will remember to walk with your walker. The resident was then released from the restraint.

An interview with Staff member #103 confirmed the incident above. Staff member #103 further added that on initial approach to Resident #4, Staff member #103 heard Staff member #101 telling the resident that the restraint was used because the resident kept forgetting to use her walker.

The use of the lap belt on a specified date for Resident #4 was used as a disciplinary measure. [s. 30. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee did not comply with O.Reg 79/10, s.98, in that the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence

On a specified date Staff member #103 witnessed Resident #4 to be improperly restrained, while Staff member #101 sat near by. When questioned by Staff member #103, Staff member #101 indicated that the resident was restrained so that the resident will remember to use a walker. After approximately 20 minutes, Staff member #101 approached Resident #4 saying now you will remember to walk with your walker. The resident was then released from the restraint.

There is no indication in the resident's health care record for the use of a restraint and there is no indication related to the common law duty.

The above incident describes Resident #4 to be confined. The home's DOC reported to the Inspector that the incident was not reported to the police force. [s. 98.]

Issued on this 30th day of July, 2013

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

Amanda Ni RO LTCH Inspector

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2013_200148_0027
Log No. / Registre no:	O-000492-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2013
Licensee / Titulaire de permis :	ALMONTE GENERAL HOSPITAL 75 SPRING STREET, ALMONTE, ON, K0A-1A0
LTC Home / Foyer de SLD :	FAIRVIEW MANOR 75 SPRING STREET, ALMONTE, ON, K0A-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RAY TIMMONS

To ALMONTE GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;

(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) shall set out the consequences for those who abuse or neglect residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall ensure:

1. The policy to promote zero tolerance of abuse and neglect of residents, entitled "Abuse or Suspected Abuse of a Resident" is amended:
i. to clearly set out what constitutes abuse and to ensure that the policy is consistent with O.Reg 79/10, (2) 1 and O.Reg 79/10, 5.
and
ii. to contain an explanation of the duty under s.24 of the Act to make mandatory reports.

2. All staff members are provided education related to the policy amendments, as referenced above.

3. A quality monitoring program is in place to ensure that the duty under s.24 of the Act to make mandatory reports is applied, as further described by the June 13, 2012 Information Package:Licensee Reporting and Resident Abuse from the Director (A).

Grounds / Motifs :

1. The licensee did not comply with LTCHA 2007, S.O., 2007, c.8, s.20(2) (b) and (d), in that the licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect and contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Policy # VI-G-10.00 entitled Abuse or Suspected Abuse of a Resident was provided to the Inspector by the DOC upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy does not clearly set out what constitutes abuse and neglect in that:
- the policy does not define sexual abuse or verbal abuse.
- the definition of physical abuse does not clearly set out that physical abuse includes physical force by anyone, does not include the administering or withholding of a drug for an inappropriate purpose and provides no distinction between resident to resident physical abuse and physical abuse by anyone, as defined by O.Reg 79/10, 2(1).
- the definition of emotional abuse does not include gestures, actions,

behaviours or remarks and provides no distinction between resident to resident emotional abuse and emotional abuse by anyone, as defined by O.Reg 79/10, 2 (1).
- the definition of neglect does not include the failure to provide treatment, care or assistance and does not include inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents, as defined by O.Reg 79/10, 5.

A review of the Abuse policy demonstrates that the policy does not include an explanation of the duty under Section 24 of the Act, in that a person who has reasonable grounds to suspect that 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 shall be immediately reported to the Director.

Findings related to LTCHA 2007, s.76 (4) (WN#3) and LTCHA 2007, s.24 (1) 2. (WN #6), further support the additional required action of a Compliance Order. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee shall ensure:

1. The policy to promote zero tolerance of abuse and neglect of residents, entitled "Abuse or Suspected Abuse of a Resident" is amended:
i. to contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
ii. to identify measures and strategies to prevent abuse and neglect
and
iii. to identify the training and retraining requirements for all staff, as outlined by O.Reg 79/10, s.96(e)(i) and (ii)

2. All staff are provided education related to the policy amendments, as referenced above.

3. A quality monitoring program is in place to ensure the policy is implemented and effective in promoting zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10, s.96 (b), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

Policy # VI-G-10.00 entitled Abuse or Suspected Abuse of a Resident was provided to the inspector by the DOC upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy contains procedures and interventions to deal only with staff members who have been found guilty of abuse and staff members who pose imminent threat. The policy does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

The licensee failed to comply with O.Reg 79/10, s.96 (c), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

A review of the Abuse policy demonstrates that the policy does not identify

measures and strategies to prevent abuse and neglect.

The licensee failed to comply with O.Reg 79/10, s.96 (e), in that the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii. situations that may lead to abuse and neglect and how to avoid such situations.

A review of the Abuse policy demonstrates that the policy does not identify the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii. situations that may lead to abuse and neglect and how to avoid such situations.

Findings under LTCHA 2007, s.76(4) (WN#3) and LTCHA 2007, s.23 (1)(b) (WN#5) support the additional required action of a Compliance Order. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of July, 2013

Signature of Inspector / Signature de l'inspecteur : Amanda Nixon RD

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

Service Area Office / Bureau régional de services : Ottawa Service Area Office