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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2015	2014_362138_0023	O-001230-14, O-000670-14	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

Long-Term Care Home/Foyer de soins de longue durée

ALMONTE COUNTRY HAVEN
333 COUNTRY STREET P.O. BOX 250 ALMONTE ON K0A 1A0

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

PAULA MACDONALD (138)

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): January 13 and 14, 2015.

Inspector completed an inquiry Log# O-001536-15 in addition to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Several Registered Practical Nurses (RPNs), a Registered Nurse (RN), several Personal Support Workers (PSWs), and a Resident. The inspector also reviewed two Critical Incidents, reviewed the home's policies on abuse, reviewed internal investigation documents, reviewed several employee files for annual training, reviewed an employee file for a criminal reference check, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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	Legendé 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 failed to comply with section 24. (1) 2. of the Act in that the licensee has failed to 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.

On an evening in July 2014, a PSW, Staff #100, was observed by another PSW, Staff #101, to swear and speak inappropriately to Resident #001, handle the resident roughly, and inappropriately place her hands on the resident. Shortly after the incident was observed, Staff #101, who was on orientation as a new employee, called her mentor to report the incident and seek advice. The mentor, Staff #106, was a fellow PSW who was an employee of the home and directed Staff #101 to report the incident to administration when she was in the home next. Staff #101 made a report of the incident the following day to a RPN, Staff #104. The home commenced an internal investigation which concluded in disciplinary action for Staff #100 for abuse to Resident #001. The home only informed the Director of the incident when it submitted a Critical Incident Report to the Director five days after the incident was witnessed by Staff #101 and four days it was reported to the home. [s. 24. (1)]

2. At approximately 6:15pm on an evening in October 2014, Staff #100 was witnessed by three other PSWs to speak inappropriately to Resident #002, to be rough with the resident, and to slap the resident. The incident was immediately reported by the three PSWs to the charge RN, Staff #105. Staff #105 stated to the inspector that she had reported the incident to the Director of Care via telephone soon after the incident was reported to her. The Director was not made aware of the incident until later the next day when the home submitted a Critical Incident Report to the Director at 3:03pm. [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 a person who has reasonable grounds to suspect that abuse of a resident by anyone 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

In accordance with this section and section 79. (3) (c) of the Act, the home is required to post the home's policy to promote zero tolerance of abuse and neglect of residents in a conspicuous and easily accessible location. The inspector toured the home on January 14, 2015 to locate the posted copy of the home's policy to promote zero tolerance of abuse and neglect of residents and was not able to locate a copy. The inspector spoke with the home's Administrator who stated that she was not aware that the policy was required to be posted. The Administrator verified by checking the two possible information boards used for posting of information in the home and was not able to locate a copy of the policy. The Administrator again stated to the inspector that she was not aware that it was a requirement to post the home's policy to promote zero tolerance of abuse and neglect in the home and immediately ensured that it was posted. [s. 79. (1)]

Issued on this 23rd day of January, 2015

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

Original report signed by the inspector.