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
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# Original Public Report

| Report Issue Date: November 12, 2024 |
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| Inspection Number: 2024-1192-0003 |
| Inspection Type:<br>Critical Incident |
| Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership |
| Long Term Care Home and City: Almonte Country Haven, Almonte |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 7, 12, 2024

The following intake(s) were inspected:

- Intake: #00125411 - Alleged staff to resident physical/emotional abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Reporting and Complaints

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the zero tolerance of abuse and neglect of residents policy was complied with.
Specifically, the licensee failed to ensure that follow up of care for a resident by medical and nursing assessment was completed and documented at the time of an alleged staff to resident physical abuse incident on a day in August, 2024.

Sources: Interview with DOC and resident record review [000728]

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that an incident of alleged staff to resident physical abuse was reported immediately to the Director on a day in August, 2024.
The staff to resident alleged physical abuse incident was then reported late to the

Director on a day in August, 2024.

Sources: Resident record review and an interview with the Director of Care [000728]

## WRITTEN NOTIFICATION: Police Notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service 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. 246/22, s. 105, 390 (2).

The licensee has failed to notify the police at the time of an alleged staff to resident physical abuse incident involving a resident on a day in August, 2024.

Sources: Interview with DOC and resident record review. [000728]