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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2019	2019_708548_0002	006923-18, 009344-18, 009762-18, 011108-18, 011286-18, 016337-18, 017564-18, 020830-18, 020853-18, 025606-18, 032943-18	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

RUZICA SUBOTIC-HOWELL (548), ANANDRAJ NATARAJAN (573)

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 18, 21,22,23,24,25,28,29, 2019

Critical Incident Reports were inspected related to: resident to resident physical altercation, resident behaviours, staff to resident abuse and alleged resident to resident sexual abuse.

Review of resident health care records, relevant home policies, observed staff to resident interactions and resident to resident interactions.

During the course of the inspection, the inspector(s) spoke with Residents,Director of Care, Assistant Director of Care, Registered Nurse,Registered Practical Nurses, Personal Support Workers and Behavioural Support Worker.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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 immediately report to the Director abuse of a resident that resulted in harm.

Physical abuse is defined for the purpose of the LTCHA, 2007 and O.Reg 79/10 as: the use of physical force by a resident that causes physical injury to another resident.

Critical Incident Report (CIR) was submitted to the Director in March 2018, one day after the incident of an alleged resident to resident physical altercation were a resident sustained minor injury.

CIR was submitted two days post a resident to resident physical altercation incident in May 2018 where one resident sustained several minor injuries as a result of the altercation.

A CIR of a resident to resident physical altercation in August 2018 was reported one day after the incident. A resident sustained minor injury.

A CIR in December 2018 was reported to the Director one day after a resident to resident physical altercation that negatively affected a resident's health.

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A CIR was submitted to the MOHLTC related to resident to resident alleged sexual abuse that occurred in May 2018.

On January 25, 2019, Inspector #573 spoke with the DOC, who stated that the charge RN was aware of the alleged sexual abuse incident and the incident was reported one day later to the Director. [s.24 (1)]. (573)

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.