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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 13, 2024	
Original Report Issue Date: April 25, 2024	
Inspection Number: 2024-1456-0003 (A1)	
Inspection Type: Critical Incident Follow up	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Amended By Dee Colborne (000721)	Inspector who Amended Digital Signature Dee Colborne (000721)

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO#001 from Inspection 2024-1456-0003, O'Reg 246/22 s. 19 (2) was amended to change the compliance due date to July 5, 2024.

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Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Dee Colborne (000721)	Additional Inspector(s) Ashley Martin (000728)
Amended By Dee Colborne (000721)	Inspector who Amended Digital Signature

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CO#001 from Inspection 2024-1456-0003, O'Reg 246/22 s. 19 (2) was amended to change the compliance due date to July 5, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 10, 12, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00093564 - COVID Outbreak
- Intake: #00108551 - Follow-up #: 001 - FLTCA, 2021 - s. 184 (3)
- Intake: #00110296 - Loss of Resident-staff communication and response system
- Intake: #00110461 - Alleged resident to resident physical abuse between residents
- Intake: #00112875 -Fall of a resident resulting in an injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1456-0001 related to FLTCA, 2021, s. 184 (3) inspected by Dee Colborne (000721)

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours- Written approaches to care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to have written approaches to care that may result in responsive behaviours.

Rationale and Summary:
On a specified date in March, 2024, an incident of resident-to-resident physical abuse resulting in injury took place involving two residents. At the time of the incident, no identified approaches to care were noted in the plan of care for one of the residents.

During an interview with ADOC #100, they confirmed that approaches to care with a focus of Responsive Behaviours should have been included in the plan of care.

During an interview with BSO #116, they confirmed that no referral for Behaviours Support was initiated for a resident despite behaviours noted in the progress notes prior to the incident on a specified date in March 2024.

Failing to have written approaches to care increases the risk of responsive behaviours posing a safety concern for residents and staff.

Sources: Interview with ADOC #100, interview with BSO #116 and resident record review [000728]

WRITTEN NOTIFICATION: Responsive Behaviours- Interventions to minimize

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to identify interventions to prevent or minimize responsive behaviours for a resident.

Rationale and Summary:
On a specified date in March 2024, an incident of resident-to-resident physical abuse resulting in injury took place involving two residents. Following a review of the progress notes, no written strategies were in place to prevent or minimize responsive behaviours for a resident.

During an interview with ADOC #100, they confirmed that written strategies to prevent responsive behaviours should have been implemented.

During an interview with BSO #116, they confirmed that no referral or interventions to minimize responsive behaviours was initiated for a resident.

A Resident's record review confirmed that no strategies were in place to prevent, minimize or respond to the responsive behaviours.

Failing to ensure written strategies are in place to minimize responsive behaviours, increases a safety risk to residents and staff.

Sources: Interview with ADOC #100, interview with BSO #116 and a residens record review.
[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 ensure that police were notified following a resident to resident physical abuse incident on a specified date in March 2024.

Rationale and Summary:

Following an incident of resident to resident physical abuse, the police were not notified. In reviewing the critical incident confirmation was received that police were

not notified at the time of the incident.

During an interview with ADOC #100, confirmation was received that police authorities should have been contacted following the incident.

The licensee's failure to immediately report the physical abuse to the police resulted in no police investigation being initiated.

Sources: Interview with ADOC #100 and a residents record review.
[000728]

COMPLIANCE ORDER CO #001 Communication Response System Equipment

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Take corrective action to ensure the homes communication and response system (call bells) is fixed to alert the nursing staff via pagers or phones by the compliance due date.

B) Have a process in place to ensure call bells are answered immediately on all

shifts, including night shift, until the call bell system is fully functional that nursing staff can be alerted to the call bells via pager or phones.

C) Perform daily documented audits on the call bell response times, for one resident per resident home area per day, for the previous week, with documented follow up action to determine the root cause when delays in response times have been recorded.

D) Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that the homes communication and response system (call bells) is in a good state of repair.

Rationale and Summary:
A critical incident report (CI) was submitted to the Director on a specified date in February 2024 indicating a failure with the homes communication system and that it would be fixed by a technician by end of day that day.

Upon review of the call bell report on a specified date in April, 2024, for a resident room, for the time period between specified dates in March 2024- April 2024, there were 11 instances of wait times between 6-10 minutes; two instances of wait times between 10-15 minutes and one instance of wait times between 20-30 minutes. Further review of the call bell report for another resident room, for the same time period, there were four instances of wait times longer than 10-20 minutes in duration and four instances where wait times for the call bell to be answered were from 21-38 minutes long.

On a specified date in April 2024 during the morning hours, Inspector noted a call bell light, (green in colour), lit up at a resident room on the wall. Inspector entered the resident's room and noted a resident in the washroom. Inspector came out of the room and noted the ceiling monitor in the hall for call bells was flashing between room two resident rooms. Inspector looked down hall and noted the ceiling call bell light, (white in colour), illuminated at another resident room. Inspector could hear no audible sound and waited to see if staff would arrive. At a specific time, the inspector noted a staff member go into a resident room and speak to the resident and then came out and the call bell light was off and the PSW then came to answer another resident room call bell and told the resident they would be right back as they had to go get help. PSW then exited the resident room.

During an interview with a PSW on a specified date in April 2024, they confirmed that the call bell system calls do not go anywhere, and that the system is broken and that the bed sensors alarm also do not ring into the call bell system anymore. They confirmed that the management of the home keeps telling them, the system is being looked at, but it has been out since February 2024.

During an interview with a resident, they confirmed that the call bells have not been working right for a few months. They stated they were given a handheld bell to use at one time, but that staff came to take it back to give to someone else. They confirmed that they've had to wait for a considerable amount of time for staff to answer their call bell citing that it was a 40-minute wait on one occasion.

During an interview with two PSW's on a specified date in April 2024, they confirmed that the call bell system used to ring to pagers that they carried, but this is no longer the case. They have to try to do regular checks to look at lights or look at the ceiling monitor to see if its illuminated. They can get busy and not always know when a call bell is going off. They confirmed that at the beginning of the

breakdown a few months ago, the wait times were upsetting residents. They confirmed this is affecting all resident areas of the home.

During an interview with two PSW's on a specified date in April 2024, they confirmed that they previously had pagers to alert them to call bells and bed sensors but haven't had this for a long time and they are told by management the system is outdated. They confirmed that on night shift, there is only one PSW assigned to two halls, and that if you are in a room assisting a resident, you have no idea if a call bell has gone off as you can't see the ceiling display until you come out of the room to check.

During an interview with Environmental Services Manager and the Director of Care (DOC), they both confirmed that there was initially a breakdown in the call bell system related to a server breakdown. This was remedied, and then the ceiling display wasn't working as reported to the Director on a specified date in February 2024. It was fixed that day and the issue now has to do with IT issues and getting the pagers and phones connected to the call bell system so that staff don't have to keep an eye out by looking at the ceiling display to know what call bell is going off. Both confirmed they are aware at how long the system is taking to get fixed. The DOC further confirmed that they no long have the staffing related to shortages to have a staff sit in the corners of both halls so that the ceiling display could be monitored.

Failure to ensure the communication response system is in good repair, increases the risk of harm to residents for call bells to be answered in a timely manner.

Sources: Critical Incident report, Homes call bell reports, Inspectors observations, interviews with a resident, PSW's, DOC, Environmental Services Manager and other

staff.
[000721]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:
A) Educate PSW's #112, #113, #118 and #119 staff working on a specific home area on resident and staff hand hygiene requirements during meal service, including requirements of staff to support residents with performing hand hygiene prior to meals, as per evidence based best practice standards.

B) Perform weekly audits, alternating meals (e.g. breakfast, lunch and supper), on hand hygiene during meal service. Audits are to be conducted until consistent compliance to the Infection Prevention and Control program related to hand hygiene is demonstrated.

C) Take corrective actions to address staff non-compliance related to hand hygiene as identified in the audits.

D) Written records, which will include the date the education was provided and by whom, of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard issued by the Director with respect to infection prevention and control measures for hand hygiene.

The home failed to ensure residents were supported to perform hand hygiene prior to receiving a meal, as part of the IPAC program, was followed by staff during meal service in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes September 2023" (IPAC Standard).

Specifically, residents did not receive support from staff in the second floor dining room of a specific resident unit area with hand hygiene prior to a lunch meal as required in the Hand Hygiene Program requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary:
Ona specified date in April 2024-inspector #00721 observed several PSW staff bringing in residents to a specific resident dining room between a specified time period for a specific meal and again at the end of the meal. A PSW entered the dining room after the majority of residents were seated to assist with the meal process.
During this time inspector was able to observe the entire entry of all residents on a specified unit into the dining room. No residents were cued or offered assistance of hand hygiene, by staff upon entering the dining room and being seated nor before starting to eat their meal. Inspector observed the end of the meal process and as

residents were taken out of the dining room, they were not cued or assisted with any hand hygiene prior to leaving.

During an interview with two PSW's on a specified date in April 2024, both confirmed that they did not assist residents with hand hygiene prior to meals and stated they only do this during outbreaks.
During an interview with IPAC lead #103 on a specified date in April 2024, they confirmed that staff are to assist residents with hand hygiene prior to and after any meal service.

Failure to ensure that residents are assisted with hand hygiene prior to meals increases the risk of transmission of disease to residents.

Sources: Inspector observations, interviews with PSW's, IPAC lead #103 and other staff.
[000721]

This order must be complied with by June 3, 2024

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

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.