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

Original Public Report

Report Issue Date: October 17, 2024
Inspection Number: 2024-1456-0007
Inspection Type: Critical Incident Follow up
Licensee: Almonte General Hospital
Long Term Care Home and City: Fairview Manor, Almonte

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8-10, 15-17, 2024

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00117070 / CI #2973-000016-24; Intake: #00122559 / CI#2973-000030-24; Intake: #00124646 / CI# 2973-000033-24 - Resident to resident physical abuse

The following intake was completed as a Compliance Order Follow Up:

- Intake: #00123832 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (1) (c) related to plan of care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1456-0006 related to FLTCA, 2021, s. 6 (1) (c)

inspected by Pamela Finnikin (720492)

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan.

Specifically, the resident did not receive 1:1 monitoring in August 2024 as specified in the plan of care, resulting in a physical altercation with another resident. There was actual harm as a result of the plan of care not being provided as there were injuries to the other resident.

Sources: Resident's health care records and interview with ADOC and a PSW.

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