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
Apr 17, 2015	2015_330573_0006	O-001508-15	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

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): February 12 and 13, 2015.

During the course of the inspection, the inspector conducted critical incident inspections for log #O-001508-15, O-001583-15, O-001585-15 and O-001586-15.

The inspector reviewed the resident's health care records, including plans of care, progress notes, and clinical assessments. Inspector also reviewed four critical incident reports and the home's policy and procedures for Falls Prevention & Management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), a registered nurse (RN), four registered practical nurse (RPN), three personal supports workers (PSW), a resident family member and a resident.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **2 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	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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 31.(1) of the Act in that the licensee failed to ensure that a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care.

A review of Resident #003's health care record indicated that Resident #003 is legally blind and had a fall on a specific day in January 2015 that resulted in transfer to hospital with a fracture. Prior to the fall, Resident #003 had been ambulating using a walker with one person assistance.

On February 12 and 13, 2015 Inspector #573 observed Resident #003 seated in a wheel chair with a side closing seat belt in place and the seat belt lock was placed on the bottom of the Left side of the wheelchair back rest. Inspector #573 spoke to the Resident #003 who stated that she/he could not undo the wheel chair lap belt.

Resident #003's Plan of Care was reviewed and there was no indication that Resident #003 required a wheel chair seat belt restraint.

On February 13, 2015 during an interview, PSW Staff #102 stated that she applied the wheel chair seat belt for Resident #003 and further stated that she was not aware that resident is physically incapable of removing the seat belt due to her/his health status.

In an interview on February 13, 2015 RPN Staff #101 stated that because Resident #003 is legally blind and with her/his current health status, Resident #003 is now confined to a wheel chair. The RPN staff further stated that resident does not have a restraint and PSW staff members are not to apply a wheel chair lap belt restraint to Resident #003. [s. 31. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg. 79/10 section 107 (1) 5, whereby the Director was not informed immediately of an outbreak of communicable disease as defined by the Health Protection and Promotion Act.

The Director of Care was interviewed by Inspector #573, and indicated the Public Health Unit had the home in an Enteric Outbreak on December 24, 2014.

The Director was informed of the outbreak via the Critical Incident System on January 11, 2015. [s. 107. (1) 5.]

2. The licensee failed to comply with the O. Reg 79/10 section 107.(3.1)(b), whereby the Director was not informed within three business days after the occurrence of an incident that caused an injury, for which the resident was taken to hospital resulting in a significant change in Resident's health condition.

On a specific day in January, 2015, Resident #003 had a fall. On the same day the resident was transferred to the hospital and diagnosed with a fracture. The fall incident resulted in significant change in the Resident’s health status.

The Critical Incident Report for Resident #003 was submitted after 3 business days.

On a specific day in January, 2015, Resident #002 had a fall with an injury. On the same day the resident was transferred to hospital for an assessment and was diagnosed with a fracture which resulted in significant change in the Resident’s health status.

The Director was informed 8 business days after the occurrence of the incident which resulted in the significant change in the Resident’s #002 health status.[s. 107. (3.1) (b)]

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Issued on this 17th day of April, 2015

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

Original report signed by the inspector.