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**


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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 17, 2018 | 2018_583117_0001 | 009048-18 | Resident Quality Inspection |

### 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

LYNE DUCHESNE (117), JANET MCPARLAND (142)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): May 7, 8, 9, 10, 14, 15 and 16, 2018**

**During the course of the inspection, the inspector(s) spoke with the home's Chief Executive Officer, Director of Care, registered nursing staff (RN and RPNs), personal support workers (PSWs), Life Enrichment Team staff, housekeeping staff, Resident Council President, Family Council representative, several residents as well as several resident family members.**

**As part of the inspection several resident health care records were reviewed, Inspectors conducted a tour of the home, observed resident rooms and common areas, observed snack passes, infection control practices, observed a medication administration pass, observed the provision of resident care and services as well as reviewed minutes of the Resident Council meetings for the past three months.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Residents' Council**
**Skin and Wound Care**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #007 has been in the home for the several months. The resident has dementia. The resident is identified as being independently mobile with no use of ambulatory aids.

Resident #007 was observed by Inspector #117 on May 8, 2018 to be sitting on the edge of a bed. The bed was noted to have two quarter rotary side rails at the head of the bed. The side rails were in the assist position. The resident was observed to use the side rails to sit up and to get in and out of bed.

A review of the resident's health care record was conducted. The resident's two most recent quarterly RAI MDS assessments identify the use of side rails for bed mobility assistance. Orders and consent for the use of the side rails as a personal assistance services device (PASD) are identified in the resident's chart and authorized by the resident's substitute decision maker. A review of resident #007's current plan of care and Kardex does not identify the use of side rails as PASDs for bed mobility assistance.

Inspector #117 interviewed PSWs # 105 and 106 regarding resident #007's use of side rails and mobility needs. Both PSW #105 and #106 indicated that resident #007 is able to ambulate independently with no mobility aids. However, the resident does use the bed side rails to help sit up in bed and to get in and out of bed on a daily basis.

Inspector #117 interviewed RPN # 104 regarding resident #007's use of side rails and mobility needs. The RPN indicated that the resident does use the bed side rails to help with bed mobility and transfers in and out of the bed. The side rails are identified as being PASDs and not as restraints. RPN #104 reviewed the resident's plan of care with the Inspector. When it was noted that the side rails were not identified in the plan of care, RPN #015 said that these should be identified as PASDs in the resident's plan of care.

Resident #007's plan of care does not provide clear direction to staff and others who provide care to the resident regarding the use of quarter side rails as PASDs. [s. 6. (1) (c)]

**Issued on this 17th day of May, 2018**

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

**Original report signed by the inspector.**