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
Apr 29, 2019	2019_593573_0008	005289-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): March 26 -29, 2019, April 1 - 4, 8, 2019 on site; April 9, and 16, 2019 off site.

Complaint Log #005289-19 related to alleged staff to resident physical abuse and concerns related to resident care/ services was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a resident's Substitute Decision Maker (SDM) and the residents.

During the course of the inspection, the inspector reviewed resident health records. In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On March 27, 2019, Inspector #573 reviewed the written plan of care in place for resident #001. The plan of care indicated that resident #001, was at a risk for falls and included interventions to manage the risk of falls for the resident.

On March 27, 2019, Inspector #573 reviewed resident #001's progress notes, which indicated that resident #001 had a fall incident on a specified date. The progress notes indicated that resident #001 had pain, was unable to walk and was assisted with wheelchair for mobility following the fall incident. Further, the progress notes documentation on the next day following the fall incident, indicated that resident #001 was sent to the hospital for investigations and diagnosed with an injury. A review of the resident #001's health care record showed that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for the resident's fall incident on a specified date.

On March 28, 2019, during an interview with RPN #101, they indicated that for every resident's fall, registered nursing staff must do a nursing assessment, which is documented in the resident's progress notes, to complete an electronic falls risk assessment and resident's fall tracking tool. RPN #101 indicated to the inspector that registered nursing staff would also complete a fall incident report in the home's electronic Patient Risk Incident Management System (PRIMS).

Inspector #573 reviewed resident #001's health care record in the presence of RPN #101. Upon review, the Inspector and RPN #101 found that there was no completed fall risk assessment and no documentation in the fall tracking tool for resident #001's fall incident on a specified date.

On March 28, 2019, Inspector #573 spoke with Assistant Director of Care (ADOC), regarding the use of a post-fall assessment using a clinically appropriate assessment instrument specifically designed for the falls. The ADOC indicated to the inspector that when a resident has fallen, registered nursing staff will complete a falls risk assessment and a fall tracking tool. The ADOC indicated that registered nursing staff will also complete a fall incident report in the PRIMS. Furthermore, The ADOC indicated that this

PRIMS report is not accessible by staff nor is it a part of the resident's health care record and, therefore, was not considered as a clinical post-fall assessment tool.

The licensee has failed to ensure that resident #001 had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (Log #005289-19) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.