Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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
Jan 21, 2020	2019_683126_0031	022193-19, 024242-19, 024246-19	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

LINDA HARKINS (126)

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): November 28, 29, December 3, 2019 and Janaury 6, 7, 8, 9, 10, 2020

During this inspection the following logs were inspected:
Log # 024242-19 (Critical Incident #2973-000014-19) and log # 024246-19 (CI #2973-000012-19) related to allegation of physical abuse resident to resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Services Supervisor, one Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers, (PSWs), one laundry staff, one housekeeping/laundry staff, one PSW Union Representative, several residents and one family member.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003, #004 and #005 personal items were labelled within 48 hours of admission and of acquiring, in the case of new items.

On November 28, 2019, Inspector #126 observed that resident #003 toothbrush and comb were on the side of the sink and were not labelled.

On November 29, 2019, Inspector #126 observed residents #004 and #005's toothbrushes were on counter in the same room and were not labelled.

Discussion held with DOC #100 who indicated that residents personal items shall be labelled and stored after utilization.

The licensee failed to ensure resident #003, #004 and #005 personal items were labelled. [s. 37. (1) (a)]

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 residents personal items are labelled, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that resident #001 was dressed appropriately and in his own clothing.

Resident #001's Substitute Decision Maker (SDM) noticed that the resident closet was empty on a specific date in November 2019 and observed on that same day that another resident wearing resident #001's shirt. The concerns were discussed with the nursing staff at that time and they were able to locate some of resident #001's clothing.

Discussion held with Registered Nurse (RN) #103 who indicated that was made aware of concerns brought forward by the SDM regarding resident #001 wearing someone else clothing. Following that incident, RN #103 and Assistant Director of Care (ADOC) #101, talked to the nursing staff on the unit and to the laundry department.

Discussion held with Registered Practical Nurse (RPN) # 104 who indicated that on that specific evening, resident #001' s SDM brought forward the concerns about resident #001 was without any clothes in the closet and that another resident was wearing resident #001 clothing. RPN #104 indicated that they went to the laundry room and could not find any clothes that belonged to resident #001. Later that evening, they were able to locate some of resident #001 clothing in another resident's closet.

The licensee failed to ensure that resident #001 and another male resident were dressed in their own clean clothing.

2. The licensee has failed to ensure that resident #001 was dressed appropriately and in his own clothing.

On a specific date in December 2019, resident #001's Substitute Decision Maker (SDM) provided camera footage segment which we can see a Personal Support Worker (PSW), that, after changing the resident does not pull the pijama bottom back up to the hips and left it down to the knees.

Discussion held with Director of Care (DOC) #100 who indicated that was not acceptable practices. The DOC indicated that they will follow up with the nursing staff on thie unit.

Discussion held with PSWs #110, #111 and #112 who works night shift regularly and they indicated that they are aware that pijama bottom need to be pulled up to the waist and that it can increased the risk of falls if left above the knees.

The licensee failed to ensure that resident #001 was dressed appropriately. [s. 40.]

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 residents are dressed appropriately and in his or her own clean clothing, to be implemented voluntarily.

WN #3: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The Substitute Decision Maker visited the home on a specific date in November 2019 and observed resident #001 with small cuts to the face as a straight razor was utilized instead of using the electric razor.

Discussion held with Registered Practical Nurse (RPN) # 117 and Personal Support Worker (PSW) #102 who indicated that resident #001 is to be shaved with an electric razor not a straight razor and staff are aware.

RPN #117 indicated that they were aware that an electric shaver is part of the plan of care for resident #001.

The licensee failed to ensure that resident #001 was shaved with the electric razor a per the plan of care. [s. 6. (7)]

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Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.