Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 24, 29, 2011	2011_030150_0018	Critical Incident

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Registered Practical Nurse and the Physiotherapist.

During the course of the inspection, the inspector(s) reviewed the health care records of an identified resident.

The following Inspection Protocols were used in part or in whole during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits sayants :

1. The Registered Practical Nurse (RPN) states that an identified resident needed to be brought to the dining room. The resident had no foot rests on his/her wheelchair because he/she was on a program for self propel with the wheelchair and the resident was wearing shoes with grip to facilitate self propelling. The Registered Practical Nurse states that she asked the resident to hold his/her feet up and she tilted the wheelchair backward so that the resident's feet did not touch the floor and then push the wheelchair towards the dining room. The RPN states that the resident lowered one foot to the floor while the wheelchair was moving forward and injured his/her right leg.

2. The x-ray taken showed a fracture of right tibia and fibula.

3. August 29, 2011, the physiotherapist (PT) states that often the foot rests are removed from the wheelchairs because they do cause skin injury.
The PT states that the foot rests should be use when the staff are pushing a resident in the wheelchair to prevent injury.
The PT states that an initiative is in progress to ensure that the foot rests are accessible when needed.

Issued on this 1st day of September, 2011

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