Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: March 5, 2024	
Inspection Number: 2024-1456-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Severn Brown (740785)	**Inspector Digital Signature**
Additional Inspector(s) Saba Wardak (000732)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 21, 22, 23, 26, 27, 28, 29, 2024

The following intake(s) were inspected:

- Intake: #00109167 - Pro-active compliance inspection.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home

Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
During the initial tour of the home for the inspection, it was observed that the visitor policy was not posted on the home's notice board. The Director of Care (DOC) confirmed that the visitor policy was not posted anywhere in the home.

A copy of the current visitor policy was observed to be posted on the home's notice board and it was easily accessible after the home was notified of lack of posted visitor policy.

Sources:
Observations and interview with the DOC.

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Date Remedy Implemented: February 22, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that there is a written plan of care for a resident that sets out the planned care.

Rationale and Summary
Upon reviewing Point Click Care (PCC) and E-Care documentation systems as well as a resident's health care records, it was noted that a plan of care created following the resident admission to the home was only partially completed. Specifically, the resident's plan of care did not include goals and directions for care related to the resident's medical, nursing, personal support, mental health, nutritional, dietary, religious, and spiritual care requirements.

The Assistant Director of Resident Care (ADOC) confirmed that the plan of care created following the resident's admission was only partially completed. A Registered Practical Nurse (RPN) also confirmed that they were unable to locate a copy of a written plan of care in the resident's physical health care record.

By not completing a resident's plan of care, the resident was placed at risk for not being provided the care they require.

Sources:
PCC and E-Care documentation systems, a resident's physical health care record, interviews with the DOC, ADOC, and an RPN.

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WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

1.
The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when unsupervised.

Rationale and Summary
During the course of the inspection, several doors to non-resident areas were observed open without any direct observation by a staff member. These non-resident areas were the recreation therapist office, the Director of Care office, and the Assistant Director of Resident Care's office. The Garden Walk spa room was also observed open without any direct staff supervision of the area.

The Director of Care stated that any office in resident areas and spa rooms must be closed and locked when unsupervised.

By not ensuring that all doors to non-residential areas were kept closed and locked at all-times. residents were placed at risk of unsupervised access and potential injury.

Sources:
Observations during the inspection;
Interview with DOC.

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2.
The licensee has failed to ensure that doors leading to non-resident areas on the Garden Walk and Heritage House resident home areas (RHA) were kept locked.

Rationale and Summary
During the inspection, the door labelled "A131 SPA" on Garden Walk unit, leading to a non-resident area was observed to be open and unlocked. On the same day, a Personal Support Worker (PSW) confirmed that the door should be locked and should not be accessible to residents.

Additionally, the door labelled "D236- SPA" on Heritage House unit, leading to a non-resident area was observed to be open and unlocked. On the same day, another PSW confirmed that the door should be locked and should not be accessible to residents.

Residents or staff members were not present in both non-resident areas at the time of observations.

Failing to ensure the doors to non-resident areas on both units were locked, created a risk for residents with independent mobility to have unsupervised access to these areas.

Sources: Observations on the Garden Walk and Heritage House RHA; interviews with two PSWs.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to implement that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with any standard issued by the Director. Per the Infection Prevention and Control (IPAC) Standard for Long-Term Care Home, revised September 2023; Section 3. Surveillance, requires that a home's IPAC program must include daily monitoring to detect the presence of infection in residents. Specifically, the licensee has failed to ensure that registered nursing staff in the home consistently assessed and documented their daily monitoring of residents for signs and symptoms of infectious disease on every shift.

Rationale and Summary
Upon review of the home's Daily Infection Signs and Symptoms Tracking Forms for November 2023 and January 2024, the Inspector identified multiple instances of

shifts without documentation for units Heritage House, Old Mill Place, Garden Walk, and Maple Grove.

An RPN stated that the RPNs on each shift on each unit are expected to document on the Daily Infection Signs and Symptoms Tracking Form that they completed an assessment for any signs or symptoms of infectious disease of the residents that they are responsible for. The home's IPAC Coordinator stated that the RPNs on each shift on each unit are expected to document on the Daily Infection Signs and Symptoms Tracking Form that they completed an assessment for any signs or symptoms of infectious disease. The IPAC Coordinator further stated that staff are not consistently performing the required assessments on each shift and documenting the assessments.

By not ensuring that the registered nursing staff are participating in the implementation of the home's IPAC program by completing Daily Infection Signs and Symptoms Tracking monitoring and documenting their assessments, residents are placed at risk of having unidentified signs and symptoms of infectious disease and not having those signs and symptoms communicated to other staff members in the home.

Sources:
Daily Infection Signs and Symptoms Tracking Forms for November 2023 and January 2024;
Interviews with an RPN and the IPAC Coordinator.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

The licensee has failed to ensure that the Director was informed no later than one business day about a breakdown of the communication and response system affecting all resident home areas.

Rationale and Summary
In January 2024, the Director of Care (DOC) was made aware of a system breakdown in the home's communication and response system that affected all resident home areas. Upon conducting a record review of the home's critical incident reports submitted to the Ministry of Long-Term Care, this incident was not reported to the Director.

The DOC confirmed that the home failed to report this breakdown of the system to the Director and a critical incident was not submitted.

Failing to report critical incidents to the Director as legislated, places residents at risk of harm.

Sources
Record review of the CI reports and interview with the DOC.

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WRITTEN NOTIFICATION: Drug destruction and disposal

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to comply with the home's drug destruction and disposal policy. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a drug destruction and disposal policy that ensures drugs are destroyed and disposed of in a safe and environmentally appropriate manner, and that the policy is complied with. Specifically, staff did not comply with the policy "Destruction of Medication" which was included in the licensee's Medication Management program.

Rationale and Summary
The licensee's Nursing Manual Policy No. VI-J-10.18 Destruction of Medications section 24.4.3 states that medications are not to be disposed of in sharps containers. During separate interviews, two RPNs on different units stated that they disposed of controlled substances, with a witness, in the sharps containers if a resident refused

or was unable to take their prescribed controlled medication. The DOC confirmed that the home's policy is that drugs are to be destroyed and disposed of in the designated medication waste containers found in the medication rooms.

By not ensuring that medications are only destroyed and disposed of in the designated medication disposal containers, there is potential risk for inappropriate access to drugs disposed of in unsecured sharps containers.

Sources:
Interviews with two RPNs and the DOC;
Nursing Manual Policy No. VI-J-10.18 Destruction of Medication.

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WRITTEN NOTIFICATION: Additional training - direct care staff

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
 2. Skin and wound care.

The licensee has failed to ensure that staff who provide direct care to residents receive training for skin and wound care.

Rationale and Summary
The training records for a PSW indicated they were not provided training on skin and

wound care. The home's orientation checklist for new hires does not list skin and wound care as a training subject. A Registered Nurse stated that direct care staff do not receive training for skin and wound care. In separate interviews, the Team Lead and DOC both stated that direct care staff do not receive training for skin and wound care. ADOC stated that the PSW was recently hired and was not trained on skin and wound care. The ADOC further stated this gap in training had been identified and that additional measures were now in place to ensure that mandatory training for skin and wound care would be completed by all newly hired staff.

By not ensuring that staff who provide direct care to residents receive training for skin and wound care, residents are put at risk of having negative outcomes related to skin and wound care.

Sources:
Training records for a PSW;
The home's orientation checklist;
Interviews with an RN, the Team Lead, the ADOC, and the DOC.

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WRITTEN NOTIFICATION: Additional training - direct care staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of

pain.

The licensee has failed to ensure that staff who provide direct care to residents receive training for pain management.

Rationale and Summary
The training records for a PSW indicated they were not provided training on pain management. The home's orientation checklist for new hires does not list pain management as a training subject. An RN stated that direct care staff do not receive training for pain management. In separate interviews, the home's Team Lead and DOC both stated that direct care staff do not receive training for pain management. The ADOC also stated that PSW was recently hired as a direct care staff and did not receive training on pain management. The ADOC further stated this gap in training had been identified and that additional measures were now in place to ensure that mandatory training for pain management would be completed by all newly hired staff.

By not ensuring that staff who provide direct care to residents receive training for pain management, residents are put at risk of having poor outcomes related to pain control and management.

Sources:
Training records for a PSW;
The home's orientation checklist;
Interviews with an RN, the Team Lead, the ADOC, and the DOC.

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WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee failed to ensure that staff who provide direct care to staff received annual training in the areas of pain management, falls prevention and management, and skin and wound care.

Rationale and Summary
In accordance with the Fixing Long-Term Care Act, 2021, staff are required to receive annual training in specified areas. Upon review of a PSW and RPN's training records, no training for pain management, falls prevention and management, and skin and wound care was found for 2023. During separate interviews with an RN and the ADOC, both stated that direct care staff do not receive annual training in pain management, falls prevention and management, and skin and wound care. The DOC stated that direct care staff do not receive annual training for pain management or skin and wound care. The ADOC further stated this gap in training had been identified and that additional measures were now in place to ensure that mandatory training would be completed annually by all staff.

Failure to ensure staff training is completed in the areas of pain management, falls prevention and management, and skin and wound care puts residents at risk of

harm.

Sources:
Training records of a PSW and RPN;
Interviews with an RN, the ADOC, and DOC.

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