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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 19, 2016	2016_384161_0045	013470-16	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

KATHLEEN SMID (161), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 11, 12, 13, 14, 2016.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed the Admission Process, Infection Control and Quality Improvement & Required Programs checklists, residents' health care records, salient home policies and procedures, Resident and Family Council minutes. The inspector(s) observed resident rooms, resident common areas, the administration of medication and the delivery of resident care and services.

During the course the inspection, the inspector(s) conducted a Critical Incident Inspection Log #028566-16 related to alleged staff to resident emotional and verbal abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of Residents' Council, President of Family Council, Personal Support Workers, Housekeeping Aides, Environmental Supervisor, Life Enrichment Team Lead, Registered Practical Nurses, Registered Nurses, Assistant Director of Care, Director of Care and the Chief Executive Officer.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of

movement and which the resident is unable to physically or cognitively remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent has been obtained and documented from the resident or by the resident's substitute decision maker.

1) On two identified dates in October, 2016, Inspector #573 observed resident #005's bed with two (2) quarter bed rails in the upright position on both sides of the bed frame. The two (2) quarter bed rails were placed in the middle of the bed frame.

Inspector #573 reviewed resident #005's health care record which indicated that the resident was at high risk for falls. To ensure the resident's safety, the written plan of care directed staff to ensure that two side rails are to be used when the resident is in bed.

On an identified date in October 2016, during an interview with Inspector #573, RPN #106 indicated that the two (2) quarter bed rails were used to assist with resident #005's positioning and bed mobility. The RPN #106 indicated to the inspector that the two (2) bed rails were used as a PASD. Further, RPN #106 indicated that resident #005 was physically unable to release the bed rails on her/his own.

Inspector #573 reviewed resident #005's health care record with the RPN #106 and there was no consent that was obtained and documented regarding the use of two (2) bed rails as PASD either from the resident or from the resident's SDM.

2) On two identified dates in October 2016, Inspector observed resident #015 sitting in a wheel chair with a front closing lap belt. The resident's multiple medical conditions precluded the resident's ability to release the lap belt on her/his own. Inspector #573 reviewed resident #015's written plan of care which directed staff to apply a front closing lap belt for the resident's positioning and safety while sitting in the wheel chair.

On an identified date in October 2016, during an interview, RPN #107 indicated that the front closing lap belt for resident #015 was used as a positioning device. RPN #107 indicated to the inspector that the front closing lap belt was not used to restrain the resident and indicated that it is used as a PASD. Further, RPN #107 indicated that resident #015 was physically not capable to release the lap belt on her/his own.

Inspector #573 reviewed resident #015's health care record with the RPN #107 and noted that there was no consent that was obtained and documented regarding the use of a front closing lap belt as a PASD either from resident #015 or from the resident's SDM.

[Log #028566-16; #573] [s. 33. (4) 4.]

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 the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.