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

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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
Dec 3, 2020	2020_548756_0014	007738-20, 009267-20, 010139-20, 013804-20, 015007-20, 016276-20, 018311-20	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

LISA CUMMINGS (756)

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): August 18-21, 26-27, 31, September 1-3, 8-11, 14-16, October 26, and 28, 2020.

Log #007738-20 - a complaint regarding interactions between residents, interactions of staff with residents and appropriate wearing of clothing
Log #009267-20 - a complaint regarding resident clothing and laundry services

Log #016276-20 - a complaint regarding overnight supervision of the resident and the nutritional needs of the resident
Log #013804-20 - a complaint regarding the appropriateness of clothing worn, the time of day the resident is woken, laundry services, and the consent for medication
Log #010139-20 - a complaint regarding transporting the resident in their wheelchair, interactions between residents, laundry services, alleged use of a physical restraint, and the resident's nutritional needs.
Log #015007-20 - a complaint concerning transfer techniques used, and the alleged use of a chemical restraint
Log #018311-20 - a complaint regarding bedtime routine and the personal care of a resident

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Physiotherapist, a Pharmacist, Laundry staff members, a Hairdresser, and residents.

In addition, observations were completed of the provision of personal care and transfers, of dining and nutrition services, the resident's room and washroom, of laundry services and the resident's available clothing, and of the interaction of staff and residents. A review of relevant records was conducted including resident healthcare records with the Daily Food and Fluid Intake Record, physician' orders and the Medication Administrator Record (MAR), Behavioural Support Ontario dementia observations worksheets and data collection sheets, video camera footage provided by the Substitute Decision Maker (SDM), documents from consultation with the Geriatric Psychiatry and Behavioural Support Community Outreach Team, emails between staff and the SDM, and policies #V11-G-40.40 'Lift Procedures' reviewed April 2019, 'Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances' reviewed January 2017, and 'Medication Pass' reviewed January 2017.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 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. 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 saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting the resident.

The Substitute Decision Maker (SDM) provided video camera footage of the resident being transferred from laying in bed to standing with the assistance of Personal Support Workers (PSWs). The video segments showed a PSW holding the resident's hand and then pulling the resident to a standing position by that hand, a PSW assist the resident to transfer from laying in bed to seated at the side of the bed by placing their arm at the back of the resident's neck during the pivot, and a PSW place their arm under the resident's arm and armpit to help transfer the resident from seated at the side of the bed to standing.

The physiotherapist confirmed that the transfers on the dates listed were not the techniques taught at the home. The physiotherapist stated that the resident should not be assisted to stand by pulling on their hand, that a staff member should place their arm on the resident's upper back during a pivot instead of the resident's neck, and that staff should have held the resident's forearm instead of holding under their arm and armpit while assisting the resident to stand.

Sources: Camera footage provided by the SDM, Policy #V11-G-40.40(c) 'Moving a Resident from a sitting position to a standing position', interviews with the Physiotherapist and others. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, 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. The licensee failed to ensure that the resident was dressed appropriately in their clothing.

The resident's SDM provided camera footage segments that showed the resident being helped by PSW's to walk from the bed towards the bedroom door. The video segments showed the resident walking with the assistance of 2 PSW's when the resident's pants fell to their ankles and no attempts were observed to raise the pants higher, the resident walking with the assistance of 2 PSW's when the resident's pants fell to their ankles and a PSW was observed to pull the pants up to the resident's knees while they continued to walk, the resident walking with the assistance of 2 PSW's when the resident's pants fell from their thighs to their knees and the resident was observed trying to pull up their pants while they continued to walk, the resident walking with the assistance of 2 PSW's with the resident's pants at their thighs, and the resident walking with the assistance of 2 PSW's in which the resident's pants were pulled up in the front but were low in the back and the resident was observed attempting to pull up the back of their pants.

PSW #121 and #122 both acknowledged that the resident's pants need to be pulled up to the waist as the resident walking with their pants at their ankles, knees or thighs could have created an increased risk of fall.

Sources: Camera footage provided by the SDM, and interviews with PSW's #121 and #122 and others. [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to provide the resident with dignity and respect when they were transported in their wheelchair by a PSW and were pushed through the privacy curtain in their room.

The SDM provided camera footage segments of the resident being assisted by PSW's into their room while seated in their wheelchair. The video segments showed the resident being brought into their room without the privacy curtain being pushed to the side first. The resident can be seen with their arms up trying to push the curtain away as they are transported through the entryway to the room.

The PSW acknowledged that they did push the resident through the privacy curtain and this was not the common practice in the home.

Sources: Video camera footage provided by the SDM and interviews with PSW #120 and others. [s. 3. (1) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that medication stored in an area of the home complied with the manufacturer's instructions as the storage of the medication continued after it had expired after 30 days.

The resident had a prescription for a medication to be administered as needed. The pharmacist confirmed that this medication was dispensed by the pharmacy on two separate dates and would have expired 30 days after each of these dates. The pharmacist stated that the bottles of medication would have had a sticker which listed the expiry date and it would have been the responsibility of the nurse administering the medication to check. The resident was administered this medication on 8 dates during the periods that this medication was expired.

This medication continued to be stored in the medication cart after the date of expiration and led to the resident receiving 8 doses that were expired.

Sources: Medication Administration Record (MAR), medication orders and nursing notes in the resident healthcare record, interviews with the Pharmacist and others. [s. 129. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication was administered to a resident as prescribed.

The resident was prescribed a medication as needed in one type of formulation. The MAR showed a dose of this as needed medication given and was documented as given in a different formulation as the prescribed formulation of this medication was not available.

The DOC confirmed that staff required a physician's order prior to changing the formulation of the medication administered.

Sources: Physician's medication orders, Medication Administration Record, Interviews with the DOC and others. [s. 131. (1)]

Issued on this 14th day of December, 2020

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

Original report signed by the inspector.