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
Mar 10, 2021	2021_548756_0003	021128-20, 021274-20, 021556-20	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), MEGAN MACPHAIL (551)

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): January 28, 29, February 1 -5, 10-12, 2021.

The following intakes were inspected:
- Logs #021556-20, #021274-20, and #021128-20 complaints related to the plan of care, medication administration, transfers, falls, infection prevention and control, and an allegation of resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), an Occupational Therapist (OT), a Registered Dietician (RD), and a resident.

During the inspection, the inspector also completed observations of the provision of personal care and transfers, of dining and nutritional services, of the resident home area including the resident's room, of laundry services, and of the interaction of staff and residents. A review of relevant records was also conducted including resident healthcare records, daily flow sheets, physician's orders and the Medication Administrator Record (MAR), video camera footage provided by the Substitute Decision Maker (SDM), documents from consultation with the Geriatric Psychiatry and Behavioural Support Community Outreach Team, and medication incident reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to grooming.

Resident plan of care specifies that the resident is to be provided care with their electric grooming tool. After the resident's bath, the PSW provided care with a disposable grooming tool which did not follow the resident's plan of care.

Sources: Daily Flow Sheet, resident's plan of care and interview with the DOC. [s. 6. (7)]

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 that care as specified in the plan of care will be provided, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident medications were administered in accordance with the directions for use specified by the prescriber.

The resident was ordered three medications once daily, another medication twice a day, and a separate medication three times a day, all at specified times.

The resident received some of their medication twice in the same day that was prescribed to be administered once daily causing the resident to receive an additional dose of five medications. As well, one of the medications ordered once daily was not administered.

Sources: medication incident report and interview with the DOC. [s. 131. (2)]

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 that medication are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 15th day of March, 2021

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

Original report signed by the inspector.