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

Ottawa District
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Original Public Report

Report Issue Date: February 23, 2023	
Inspection Number: 2023-1456-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Anandraj Natarajan (573)	**Inspector Digital Signature** Anandraj Natarajan Digitally signed by Anandraj Natarajan Date: 2023.02.23 15:19:29 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 7, 8, 9, 13, 14, 16, and 17, 2023

The following intake(s) were inspected:

- Intake: #00001233 - Complaint /concerns related to care and services to the resident.
- Intake: #00015056 - Fall of a resident resulting in an injury and transfer to the hospital.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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)
FLTCA, 2021, s. 34 (1) 5.

The licensee has failed to ensure that no resident of the home is restrained, by use of barriers, locks, or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents.

Rationale and Summary: During this inspection, the Inspector was made aware that two residents' units in the LTCH was declared on a respiratory illness outbreak. The Inspector observed that the outbreak units' entrance doors were being kept closed and locked. The inspector observations were reported to the Infection Prevention and Control (IPAC) program lead, and they confirmed that the two residents' units' entrance doors will not be kept locked. This NC was remedied on the same day of inspector's observation.

Sources: Inspector observations, and interview with the IPAC lead staff. [573]

Date Remedy Implemented: February 14, 2023

WRITTEN NOTIFICATION: Inclusion in Plan of Care - Personal Assistance Services Device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.

The licensee has failed to ensure that the use of a Personal Assistance Services Device (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 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 has given that consent.

Rationale and Summary: The Ministry of Long-Term Care received a complaint alleging that the staff failed to obtain the resident's substitute decision maker (SDM) consent prior to the use of a wheelchair's physical device. In an interview, the RN indicated to the Inspector that the wheelchair's physical device was used to assist with the resident's positioning in their wheelchair. The RN indicated to the Inspector that the physical device was used as a PASD. Furthermore, the RN acknowledged that the staff failed to obtain the resident's SDM consent prior to the use of the PASD.

There was a potential risk of harm to the resident as their substitute decision maker was not consulted and consented prior to the use of the PASD.

Sources: Resident's health care records, and interview with the RN. [573]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to the use of Personal Protective Equipment (PPE) in accordance with Routine Practices and Additional Precautions.

Rationale and Summary: The Inspector observed the residents' unit that was declared on a respiratory illness outbreak. In the Unit, there were resident rooms with droplet and contact precautions signage posted outside their room with no isolation carts containing PPE. Furthermore, the Inspector observed two PSW staff with no gown within two meters to a resident with droplet and contact precautions.

An interview with the RPN on the unit confirmed that the residents on the identified rooms were on droplet and contact precautions. In an interview, the IPAC lead indicated that the registered nursing staff were to ensure that the PPE was available and accessible to the staff on the Unit. Furthermore, they indicated that the staff were to follow the use of PPE in accordance with Routine and Additional Precautions when they provide care to the residents with droplet and contact precautions. Failing to participate in the implementation of the IPAC program increases the risk of disease transmission among the residents, staff, and others.

Sources: Inspector observations, and interview with the RPN and with the IPAC Lead. [573]

WRITTEN NOTIFICATION: Initial Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 28 (1)

The licensee has failed to ensure that the resident's initial plan of care was developed within 21 days of the admission.

Rationale and Summary: Review of a resident's health care record indicated that the initial plan of care was not completed. In an interview, the Inspector reviewed the resident's plan of care with the RN. The RN acknowledged that the plan of care was not completed and personalized for the resident. The RN stated that the resident's plan of care should be completed as the resident had been in the home more than 21 days.

Sources: Resident's health care records and interview with the RN. [573]