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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 2, 2023	
Inspection Number: 2023-1456-0004	
Inspection Type: Critical Incident	
Licensee: Almonte General Hospital	
Long Term Care Home and City: Fairview Manor, Almonte	
Lead Inspector Shevon Thompson (000731)	**Inspector Digital Signature** Shevon M Thompson Digitally signed by Shevon M Thompson Date: 2023.11.10 09:06:59 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25, 26, 27 and 30, 2023

The following intake(s) were inspected:

- Intake: #00095005 - related to the fall of a resident resulting in injury and transfer to the hospital.

Andy Natarajan, Inspector #573, was present during this inspection.

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

Infection Prevention and Control
Falls Prevention and 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. 6 (1) (a)

The licensee has failed to ensure that resident #001's written plan of care sets out the planned care for the resident's fall prevention interventions.

On October 25, 2023, inspector observed device to decrease the risk of injury beside the resident's bed. On October 27, inspector noted resident #001 seated in a wheelchair with a fall prevention device in place.

Inspector reviewed resident #001"s written plan of care. The written plan of care indicated the resident had a fall prevention device in place on their wheelchair. A review of resident #001's progress notes identified the use of two fall prevention interventions. No information was noted in the plan of care related to the use of the two fall prevention interventions.

In an interview on October 30, 2023, with the ADOC, they confirmed they were unable to find the fall prevention interventions documented in resident #001's written plan of care. On the same day, the ADOC stated that the written plan of care had been updated and provided an updated record to the inspector. The resident's written plan of care was reviewed by inspector and information related to fall prevention interventions was present.

Source: Observation of resident #001 and their room, resident #001's written plan of care, progress notes, interviews with the ADOC. [000731]

Date Remedy Implemented: October 30, 2023

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when resident #001 had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and summary
A review of resident #001's progress notes indicated the resident had fallen on a day in August 2023. Upon further review of the resident's health care record, inspector was unable to find a completed post fall assessment completed for this fall. In an interview on October 30, 2023, with the ADOC, they confirmed they were unable to provide the post fall assessment for resident #001's fall. Failure to complete a post fall's assessment may delay determining the cause of the fall and implementing any necessary post fall's interventions.

Sources: resident #001's Post Fall Assessments, progress notes, interview with the ADOC. [000731]