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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# Public Report

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| **Report Issue Date:** November 12, 2025 |
| **Inspection Number:** 2025-1456-0006 |
| **Inspection Type:**<br>Critical Incident<br>Follow up |
| **Licensee:** Almonte General Hospital |
| **Long Term Care Home and City:** Fairview Manor, Almonte |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4, 5, 6, 10, 12, 2025

The following intake(s) were inspected:

- Intake: #00154570 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 4.
- Intake: #00154571 - Follow-up #: 1 - FLTCA, 2021 - s. 36 (4)
- Intake: #00154572 - Follow-up #: 1 - O. Reg. 246/22 - s. 18 (1)
- Intake: #00159051 - ARI Outbreak

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #003 from Inspection #2025-1456-0004 related to O. Reg. 246/22, s. 53 (1) 4.
Order #001 from Inspection #2025-1456-0004 related to FLTCA, 2021, s. 36 (4)

Order #002 from Inspection #2025-1456-0004 related to O. Reg. 246/22, s. 18 (1)

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

Infection Prevention and Control
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Conditions of Licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The Compliance order #003 issued in inspection 2025_1456_0004 has not been complied with.

Specifically, the home did not comply with completing the following compliance order items: A)- not implementing the pain program entirely, B)- not having all Registered Staff trained on the pain program policy involving pain assessments and documenting pain levels as well as effectiveness, D), taking corrective actions on audits when non-compliance was identified, and F), not keeping written documentation of who provided the education and the date of when the pain management program was implemented.

Sources: Homes compliance order documentation, interview with ADOC and DOC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Written Notification NC #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
In the past 36 months, a CO under O.Reg. 246/22 s. 53 (1) (4), was issued (2025_1456_0004) on August 5, 2025 and was not complied.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Conditions of Licence

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has not complied with CO #001, FLTCA, 2021, s. 36 (4) from inspection #2025-1456-0004.

Specifically, the following items were not complied with:

1.Document in every resident's chart progress notes and care plan alternatives that were considered and trialed with a detailed outcome of effectiveness and reasoning for the use of the personal assistance service device(PASD), specifically bed rails, as required. The consideration, trial and outcome should be held and discussed at an interdisciplinary level, involving the resident and/or Substitute Decision Maker (SDM). Several residents health care records were reviewed with no documented alternatives trialed and detailed outcome of effectiveness. There was no documentation on a discussion at an an interdisciplinary level, involving the resident and/or Substitute Decision Maker for all four residents.
-The home will obtain consent for use of all PASD's in the home from the resident or SDM. Consent for the use of bedrails as a PASD were not obtained for two residents when new orders were written on a specified date in September 2025.
-The home will update every resident's care plan for the use of of the PASD, specifically bed rails, including but not limited to the following: how often it

should be monitored. Several resident's health care records were reviewed and did not indicate how often their bedrails as a PASD should be monitored; and several resident's records did not specify that bedrails were being used as a PASD.

3.The Administrator or designate manager will provide education to all registered staff, both Registered Practical Nurses (RPN) and Registered Nurses (RN), on the requirements that must be in place in the resident plan of care so that bed rails as a PASD may be used. The Director of Care (DOC) and Assistant Director of Care (ADOC) indicated that the education required for the above requirement was for registered staff to review the home's new PASD Policy, however education has not been completed at this time.

Sources: Resident's health care records; Bedrail Procedure Education Sign off sheet; Email from DOC to registered staff, October 28, 2025; Personal Assistance Services Devices (PASD) Policy, Fairview Manor Manual Resident Care V11-F-10.09, Previous date reviewed May 2024; and interview with DOC and ADOC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #002**
**Related to Written Notification NC #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days

from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
In the past 36 months, a CO under FLTCA, 2021, s. 36 (4) was issued (Inspection #2025-1456-0004) on August 5, 2025 and was not complied.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Conditions of Licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has not complied with CO #002, O. Reg. 246/22, s. 18 (1) from inspection #2025-1456-0004.

Specifically, the following items were not complied with:
1.The licensee shall develop and implement a program to ensure that where bed rails are used, the resident is assessed in accordance with the prevailing practices outlined in the following document: "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003" (the Clinical Guidance document). The program is to encompass all aspects of the Clinical Guidance document including the guiding principles, policy considerations, the process/procedure considerations, risk interventions, etc.
a) Within seven business days of receiving this Compliance Order, the interdisciplinary team members as prescribed must be designated and provided with orientation training with regards to the Clinical Guidance document and their roles and responsibilities as team members.
b) All current residents using bedrails must be assessed as prescribed. Decisions to continue or discontinue usage shall be made by the interdisciplinary team(s) based on the assessments and evaluation of the relative risk of using bed rails compared to not using them for a resident. Consideration of risk includes the risk of injury or death related to the entrapment zones on the resident's bed system. Documentation must include the risk benefit assessment and all other stated requirements in the Clinical Guidance document.

2. The licensee shall develop and implement a program to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with the prevailing practices outlined in the following document: "Guidance Document – Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" (the Guidance document). The program must include, but is not limited to:
b) Staff responsible for conducting bed system evaluations must receive training and ongoing support. Their competency must be verified to ensure evaluation are

performed in accordance with the Guidance document including correct use of the testing tool and accurate documentation of results.
d) A detailed inventory of all bed systems with rails to be developed and maintained by September 2, 2025 of receiving this Compliance Order. Records must include evaluation information and results such as identifying information for the bed deck, mattress, rail type, rail positions (e.g. rotating rail in the up and or in the down position), condition of rail with corrective action as required, entrapment zone testing and results. All bed system components must be traceable. Information about mattress compatibility must be clearly and permanently marked on the bed.

3. Education for all nursing staff about the new bed safety program, including orientation to the identified entrapment zones on a bed system and consideration of the different types of rails in use throughout the home (e.g. rotating rails can be used in the up and in the down position, entrapment zones differ accordingly), key body parts at risk for entrapment, entrapment zone testing methods in general, assessment of residents for risk of entrapment within the bed system in general.

4. Document and keep a record of the education provided, including topics covered, the names of the staff in attendance, date, and who provided the education.

6. Written records will be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

During the inspection, the inspector found that:
-The developed program entitled "Personal Assistance Services Devices (PASD) Policy, Fairview Manor Manual Resident Care V11-F-10.09" was not implemented by the compliance due date (CDD) of October 31, 2025; all current residents using bed rails were not assessed as prescribed in their new program; there was no documented risk benefit assessment and all other stated requirements in the

Clinical Guidance document.
-The interdisciplinary team members as prescribed names were not documented and it was unclear if they received orientation and training on their roles and responsibilities as team members, and the dates training occurred.
-There was no developed program provided to inspector to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with the prevailing practices outlined in the following document: "Guidance Document – Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" (the Guidance document).
-There was no documentation that the staff responsible for conducting bed system evaluations competency was verified to ensure evaluations are performed in accordance with the Guidance Document including correct use of the testing tool and accurate documentation of results.
-The detailed inventory of all bed systems with rails was not complete as multiple resident's mattresses were not evaluated; all bed system components were not traceable; and information about mattress compatibility was not clearly and permanently marked on the bed.
-There was no documented education provided to all nursing staff about the new bed safety program, including orientation to the identified entrapment zones on a bed system and consideration of the different types of rails in use throughout the home (e.g. rotating rails can be used in the up and in the down position, entrapment zones differ accordingly), key body parts at risk for entrapment, entrapment zone testing methods in general, assessment of residents for risk of entrapment within the bed system in general.
-The only written records maintained and provided to the inspector for CO #002 were the bed entrapment assessments, mattress audit, and education sign off sheet for facilities staff. It was unclear which training video facilities staff were required to watch and the dates on which each bed entrapment assessment and mattress audit occurred were not documented.

Sources: Resident's health care records; Personal Assistance Services Devices (PASD) Policy, Fairview Manor Manual Resident Care V11-F-10.09, Previous date reviewed May 2024; Positioning Device/PASD/restraint Initial Assessment; Bed Entrapment Assessments; Mattress Audits; Education record for staff responsible for conducting bed system evaluations; Email from Vice-President of Patient/Resident Care, Pharmacy & Chief Nursing Executive sent to Inspector on a specified date in August 2025 and interviews with the President and Chief Executive Officer, DOC, ADOC, and Maintenance/Engineering Lead Hand AGH.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #003**
**Related to Written Notification NC #003**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
In the past 36 months, a CO under O. Reg. 246/22, s. 18 (1) was issued (Inspection #2025-1456-0004) on August 5, 2025 and was not complied.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.