



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, L1K-0E1  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
OTTAWA, ON, L1K-0E1  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

## **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 31, 2014	2014_287548_0017	O-000253- 14	Critical Incident System

### **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**

RUZICA SUBOTIC-HOWELL (548)

### **Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 27, 2014**

**During the course of the inspection, the inspector(s) spoke with Director of Care, Associate Director of Care, Registered nursing staff, Personal Support Workers.**

**During the course of the inspection, the inspector(s) Reviewed resident health care records, observed resident room and Resident common area.**

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

**Falls Prevention**



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**



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**Findings/Faits saillants :**

The Licensee failed to to comply with LTCHA, 2007 S.O. 2007,c.8,s.6 (1) (c) in that the care set out in the plan of care was not provided to the resident where the resident fell, sustained an injury and was hospitalized.

Resident #010 was admitted to a secure unit at the home on a specified day in December, 2008. The Resident #010 had been recently transferred to another unit approximately one month prior to the incident.

On a specified day in March, 2014 Resident #010 was assisted by one Personal Support Worker (PSW) using a wheeled walker to mobilize from the unit to the resident common great room where an activity was being held.

During an interview on July 30, 2014 the Director of Care (DOC) indicated that her investigative findings concluded that the PSW provided one person assist as the resident walked with a wheeled walker from the unit to the common room. The DOC indicated that the Resident #010 and PSW entered the common room where an activity was being held. The PSW remained standing by the resident and looked away from the resident to find a chair for the resident to sit in. The DOC indicated that when the PSW looked back she saw that the resident had tilted in the opposite direction of the PSW. The DOC indicated that the PSW attempted to get around the resident's walker in an effort to prevent him from tilting any further. The DOC indicated that the resident than fell.

Upon record review the Resident#010 been identified as high risk for falls and presented with a shuffling gait. The Resident #010 had been seen by the occupational therapy and physiotherapist and participated in the home's Walking Program.

On June 27, 2014 the Director of Care provided the Resident's care plan to inspector #548. Upon record review the Residents' #010 care plan indicated the resident had poor balance and was unsteady. It is noted there are several identified categories with associated interventions documented in the care plan regarding ambulation for the resident. The categories and associated interventions include:

Falls/Balance – assist Resident with all transfers and ambulation with wheelchair brought behind

Locomotion of unit- monitor for increased shuffling and gait, promote rest when tired



or upset. Promote use of walker at all times

Locomotion on unit- promote rest when tired or upset, promote use of walker for all walking, promote safe use of walker-stand tall and walk into the walker

Restorative Program- cue resident to take daily walks with walker- walk with resident, promote resident attendance to programs

Sleep and Rest- promote exercise and walking during the day, avoid excessive napping during the day

Skin integrity- promote frequent walking throughout the day

Safety devices/Restraints- to use walker for all mobility

Therapies- daily assisted ambulation with walker in hallway

Toileting- assist resident to toilet due to safety- unsteady, needs to use walker

Transferring- one person physical assist, transfer aid wheeled walker, promote use of walker for all transfers

Walk in corridor- one person physical assist, transport to and from meals in wheelchair due to safety, participate in daily walking program with two staff assist

Walk in room- one person physical assist, promote use of walker in his room

Aids to daily living- promote use of walker for all walking, walker

Upon record review it is recorded on a document titled: FairView Manor Daily Flow Sheet dated March, 2014 that the majority of the time Resident #010 was transferred to and from meals and the bathroom via walker as part of the walking program.

On June 27, 2014 it was observed by Inspector #548 that the resident's room was adjacent to the dining room.

On June 27, 2014 during each individual interview differences were noted of each staff members' understanding in the implementation of the care plan. S#112



registered staff indicated that the resident is known to be unsteady and communicated resident needs for ambulation to all staff as per the care plan prior each shift. S#112 indicated that the communication includes that the staff are to walk the resident as the resident was part of the walking program and required assistance for ambulation at all times. S#113 indicated that the resident was part of the walking program at the home. S#113 recalled that the resident going to and from the resident's room to the dining room in a wheelchair. S# 114 indicated that the resident is known to be unsteady at certain times of day and would not have ambulated the resident the distance required to walk to the common room.

During the time of the inspection the PSW who accompanied the resident to the common room was unavailable for an interview.

On June 27, 2014 the Director of Care provided to Inspector #548 a document titled: High Risk Flag Sheet for Report dated for a specified day in March, 2014. The DOC indicated that a daily flag sheet is produced and communicated to each staff member prior to each shift. The DOC indicated that it was the registered staff responsibility to communicate that the Resident#010 required assistance for ambulation at all times as indicated on the flag sheet form dated for a specified day in March, 2014.

On June 27, 2014 during interviews with S# 112, S#113 and S#114 each confirmed that it is the practice to review the flag sheet report at shift report and each person must initialize the form prior to the commencement of work.

It is noted that The DOC indicated that she was unable to locate the High Risk Flag Sheet for Report for a specified day in March, 2014.

During an interview on June 27, 2014 the DOC indicated that the resident is known to be confused at times and does not ambulate well. She indicated that she supported the PSW's assessment of the resident's ability to walk with a wheeled walker to the common room for an activity on a specified day in March, 2014. The DOC confirmed that the PSW did not have another staff member follow behind the resident with a wheelchair while ambulating as indicated in the care plan.

The plan of care does not provide clear direction to staff regarding resident's ambulation needs.



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***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 for individual resident ambulation needs, to be implemented voluntarily.***

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**Issued on this 31st day of July, 2014**

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