Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 2, 2016	2016_280541_0012	009589-16/009891-16/023713-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF FRONTENAC
2069 Battersea Road Glenburnie ON K0H 1S0

Long-Term Care Home/Foyer de soins de longue durée

FAIRMOUNT HOME FOR THE AGED
2069 Battersea Road R. R. #1 Glenburnie ON K0H 1S0

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

AMBER MOASE (541)

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): April 13 and 14, 2015

This inspection was for three critical incidents: a resident choking incident, an alleged staff to resident abuse and an alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Associate Director of Care, Registered Nurses, the Food Service Supervisor, Registered Practical Nurses, Personal Support Workers, Dietary Aides, and Residents. In addition, the Inspector also observed resident meal service, observed staff to resident interaction, reviewed resident health care records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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 is provided to the resident as specified in the plan.

Re: Log #009891-16
Critical Incident Report # M521-000006-16 was received on a specified date for an allegation of staff to resident abuse. The incident is as follows:

On a specified date resident #003 informed PSW #101 that during the previous night shift the resident rang the bell to be toileted. PSW #100 responded to the call and told the resident to pee in his/her brief. When resident #003 reported this to PSW #101, PSW #101 immediately reported the incident to the home's Associate Director of Care (ADOC) and an investigation began.

During the home's investigation PSW #100 was interviewed and confirmed resident #003's account of the incident. PSW #100 thought what she said was ok as she offered to change the resident's brief immediately afterwards.

Resident #003's current plan of care states the following in regards to toileting:
- Limited assistance x 1 staff. Commode at bedside every evening.

Resident #003 was interviewed by the ADOC during the home's investigation and was described as being upset and crying regarding the incident.

During the inspection, Inspector #541 interviewed resident #003 who recalled the incident. During interview resident #003 appeared to be upset when the incident was discussed.

The home failed to toilet resident # 003 as specified in the plan of care. [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 to ensure resident #003 receives assistance with toileting as specified in the plan of care, to be implemented voluntarily.

Issued on this 2nd day of May, 2016

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

Original report signed by the inspector.