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 soins 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
Sep 6, 2016	2016_347197_0022	021683-16/022759-16, 024910-16	Complaint

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 25-31 (on-site), Sept 1, 2 (off-site), 2016

Three logs were inspected as part of this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Assistant Director of Resident Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and resident's family members.

The inspector also observed resident care and reviewed resident health care records, internal investigation files, a critical incident report and policies/procedures related to falls prevention and management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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.

On a specified date, resident #002 fell and sustained an injury. The resident was sent out to hospital and returned with an order for a specific treatment.

Resident #002's family member indicated to the inspector that when arriving in the home on a specified date after the fall, resident #002 did not have the specific treatment applied. When the family member questioned RPN #108, he/she indicated that the RPN was unaware of the specified treatment in place.

During an interview with RPN #108 on August 26, 2016, she stated that she recalled the family member coming to her and telling her about the treatment that was to be in place for the resident. The RPN confirmed that at that time the resident did not have the treatment applied and that she was unaware of how to apply it since she does not work in the home that often and when she does, she is not always on the same unit. She stated that she called RN #107 to come apply the specified treatment.

RN #107 was interviewed on August 26, 2016 and stated that she recalls that the specified treatment was not applied by the RPN and that she was called down to the floor to complete the treatment for resident #002. She states that the instructions for applying the treatment were in the care plan and that the Medication Administration Record should have alerted the RPN to apply the treatment. She further stated that she then posted the instructions for applying the treatment on the board in the nursing station.

On a specified date, resident #002's treatment was not applied as per the resident's care plan. [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 that the care set out in the plan of care is provided to resident #002 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

On a specified date, resident #002 fell and reported pain to a specific area. The resident was monitored and an x-ray was completed in the home four days after the resident fell. The decision was then made to send the resident to the hospital.

The progress notes indicate that the resident returned from the hospital the following day with a specific treatment and instructions in place . Progress notes on the two days following the resident's return from hospital indicated the resident had increased pain and was receiving increased amounts pain medication as needed.

Resident #002 sustained another fall nine days after the first fall and was sent to hospital for assessment. The resident returned to the home the following day with no new orders.

A critical incident report was submitted to the Director three days after the second fall, with details only of the second fall. The Director was not notified of the initial fall that caused an injury to the resident for which the resident was taken to hospital and resulted in a significant change in his/her health condition. [s. 107. (3) 4.]

Issued on this 6th day of September, 2016

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

Original report signed by the inspector.