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
Feb 7, 2017	2017_444602_0003	034964-16, 000759-17	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

WENDY BROWN (602)

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): January 23-25 and Feb 1 & 2, 2017

Two complaints were inspected as follows:
Log#034964-16 concerning wound care
Log#000759-17 concerning resident care and services

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Activities Staff, Environmental Services, Residents and Family. As part of the inspection electronic and hard copy chart records were reviewed, observations of care and service delivery were made and staff interviews were completed. Additionally, written communication with external agencies and subsequent contact and recommendations were considered.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The following non-compliance is related to Log #000759-17.

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks that restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On a specified date PSW #103 exited a non residential area/room and noted Resident #001 walking down the hall, resident #003 was also observed in the hallway area. Several minutes later housekeeping #107 called out for assistance as she had found residents #001 and #003 in the on residential area/room.

The housekeeping staff had noticed resident #003 looking out into the hall from in behind the non residential area/room door; on investigation staff #107 found resident #001 was also in the room sitting on the floor. The non residential area/room door automatically locks on exit as it is a non-residential area and it was unknown as to how the residents gained access to the room. PSW #103 indicated she thought the door had shut and locked behind her. RN #108's progress notes indicated she would email maintenance regarding the automatic door locking concern.

RPN#106 indicated in an interview with Inspector #602 that maintenance had been in to examine the door/door lock and that it was currently functioning properly. In an interview the environmental services manager #110 explained that the locking mechanism and closure tension had been examined/adjusted and that the door was now closing and locking automatically as expected during all testing. There have been no reports of automatic door locking problems from staff since a specified date. [s. 9. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The following non-compliance is related to Log #034964-16.

The licensee has failed to ensure that the resident-staff communication response system, such as a call bell, can be easily seen, accessed, and used by residents, staff and visitors at all times.

Resident #004's current care plan indicates that staff is to ensure the resident's call bell is within reach when in room and that staff is to transport the resident to/from all destinations.

On a specified date in an interview with Inspector #602, resident #004's family member indicated that on some occasions the call bell was not accessible. The family member advised that this was the case on two separate specified dates.

On a specified date Inspector #602 observed Resident #004 alone in his/her room in a wheelchair facing the bed. The resident explained that he/she had just returned and indicated, with a nod toward the bed, that the call bell could be found hanging on the side rail. When Inspector #602 asked Resident #004 if the call bell could be accessed the resident tried unsuccessfully to move toward the bed. The resident was not able to reach the call bell.

On a specified date the Director of Care (DOC) was informed that Resident #004 had been observed sitting opposite the bed some distance from the call bell on return from a specified treatment. The DOC expressed concern and immediately contacted the Assistant DOC (ADOC) to ask that she speak with the department providing treatment regarding their need to ensure that when residents are returned to their room they must ensure their call bell is within reach. In a meeting on February 2, 2017 the ADOC advised Inspector #602 that she had connected with newly hired staff member who indicated they did not ensure the resident had been positioned near the call bell and will do so, always, in the go forward. [s. 17. (1) (a)]

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.