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
Apr 27, 2017	2017_505103_0017	006615-17, 007501-17, 007623-17	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

DARLENE MURPHY (103)

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 24-27, 2017

Log #007501-17 (alleged resident to resident abuse)
Log #006615-17 (alleged staff to resident abuse)
Log #007623-17 (resident fall)

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse (RPN), a Registered Nurse, the Assistant Director of Care (ADOC) and the Director of Care (DOC).

During the inspection, the inspector reviewed the resident health care records including assessments, progress notes and plan of care related to responsive behaviours and fall prevention, reviewed the home's investigation into the alleged incidents of abuse and the home's abuse policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following finding relates to Log #007501-17 and Log #006615-17:

The licensee has failed to ensure incidents of alleged physical and verbal abuse involving residents were immediately reported to the Director (MOHLTC).

O. Reg 79/10, s. 2 (1), defines physical abuse as including the use of physical force by a resident that causes physical injury to another resident.

On an identified date, the home submitted a critical incident report indicating resident #001 had received an injury as a result of a physical altercation with resident #002. RN #104, who was in charge of the building on the date of the incident, assessed the residents following the altercation.

The DOC was interviewed and confirmed the MOHLTC was notified for the first time of this incident by means of the critical incident that was submitted two days after the altercation and that RN #104 had failed to immediately notify the MOHLTC of the alleged abuse.

O. Reg 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth,

that is made by anyone other than a resident.

On an identified date, the home submitted a critical incident report indicating PSW's #102 and #105 were providing care to resident #003. The resident became agitated and raised their arm to the staff. PSW #105 responded by telling the resident not to hit them or she would in turn hit the resident back. PSW #102 reported the incident to RN #103 who was in charge of the building at the time. The RN sent an email the following morning to notify the DOC of the incident.

The DOC indicated in an interview that she became aware of the incident when she was reviewing the weekend reports. She confirmed RN #103 had not notified the MOHLTC immediately of the alleged verbal abuse and that the critical incident report submitted the following day had been the means by which the MOHLTC was first notified of the incident.

The DOC stated the ministry's after hour's number is posted at each nursing station and that staff are educated on an annual basis on the need to make immediate notifications to the MOHLTC for any alleged, suspected or witnessed incidents of abuse. The DOC indicated the charge staff were counselled in regards to the late reporting.

The home failed to immediately report two incidents of alleged resident abuse. [s. 24. (1)]

Issued on this 28th day of April, 2017

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

Original report signed by the inspector.