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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2018	2018_664602_0023 (A2)	007682-18, 008548-18, 020235-18, 023848-18, 023984-18, 023991-18, 025242-18, 028447-18	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

Amended by WENDY BROWN (602) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested the following clarifications/ wording changes to the Licensee and public reports for the Critical Incident System Inspection conducted in November 2018. The licensee has provided an email communication dated December 5, 2018 detailing the reasons for the requested amendments.
The following changes were made:
WN#1 - Public copy - A sentence was removed.
WN#2 - Public copy - A sentence was removed.
WN#3 - Public copy- "A number of these residents were" - changed to: "One of the residents was".
WN#4 - Public copy- RPN#023 - changed to RPN #123.

Issued on this 14th day of December, 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by WENDY BROWN (602) - (A2)

Amended 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): October 17, 18, 23-26 and November 2 & 5, 2018

007682-18 (M521-000012-18) - regarding a fall resulting in injury and hospitalization.

008548-18 (M521-000013-18) - regarding a fall resulting in injury and hospitalization.

020235-18 (M521-000024-18) - regarding alleged resident to resident abuse.

023848-18 (M521-000028-18) - regarding alleged neglect of residents.

023984-18 (M521-000027-18) - regarding alleged neglect of a resident

023991-18 (M521-000026-18) - regarding alleged neglect of a resident.

025242-18 (M521-000031-18) - regarding a medication incident/adverse drug reaction.

028447-18 (M521-000032-18) - regarding a fall resulting in injury and hospitalization.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Directors of Care, the Director of Care and the Administrator. In addition, observations of resident care service delivery, and reviews of the electronic record, and relevant Long-Term Care home policies were completed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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	Légende 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 :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date, at a specified time, a staff member heard a loud thump and then the ringing of an alarm. Resident #012 was found lying on the floor, injured, and in pain. The resident was transferred to hospital and later returned to the home.

The record review indicated that resident #012 had fallen on multiple occasions preceding the most recent fall. Several fall interventions were in place. The incident report notes indicated that one of the interventions was not followed.

An Assistant Director of Care indicated that the specified intervention was part of the resident's care plan and should have been in place as it was one of the prevention interventions outlined for this resident.

Resident #012 was not provided with the fall prevention/interventions set out in their 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 that will ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that their "Residents - Zero tolerance for Resident Abuse Neglect", Index Number S&S - 02 was complied with.

The policy defines Neglect as:
"the failure to provide the care and assistance required for the health, safety or well-being of a resident and includes a pattern of inaction that jeopardizes the health or safety of one or more residents.
Includes, but is not limited to, the failure to:
a) provide the ongoing care set out in a resident's plan of care
b) provide access to a physician's services when required
c) reduce and manage health and safety hazards in the home on an ongoing basis

"Policy: Resident rights, which shall be fully respected and promoted, include, but are not limited to, the rights contained in the Bill of Rights.
Abuse and neglect of any form will not be tolerated - no exceptions. Suspected or witnessed abuse must be reported and all such allegations will be treated seriously and investigated immediately."

Specifically the direction outlined on p. four (4) of six (6): "Any person must immediately report witnessed or suspected abuse/neglect to:
a) The Administrator, Director of Resident care and/or Assistant Director of Care,
b) The Ministry of Health and Long-Term Care
c) The toll free Long-Term Care ACTION line.

The following finding is related to Logs # 023848-18, #023984-18, and #023991-18

According to the home's investigation documentation, on a specified date multiple residents were found in urine soaked and/or soiled briefs and beds. One of these residents was found in unclean clothing.

Registered Practical Nurse (RPN) #116 alerted the Director of Care (DOC) #101 to the incident of alleged neglect a specified number of days after the incident occurred. Upon receiving the email the DOC contacted all Substitute Decision Makers of effected residents and began an investigation. The Director was informed of the incident (s) that same day.

The subsequent investigation lead by DOC #101 confirmed that Personal Support Worker (PSW) #111 had slept for some portion of their shift, failing to complete and document resident care. In addition, PSW #112 and #113 did not notify RN#114 that PSW #111 was sleeping. It was also noted that RN#115 was made aware of resident status by subsequent shift staff and failed to notify DOC #101 and/or ADOC #102.

The licensee failed to ensure their "Residents - Zero tolerance for Resident Abuse Neglect", Index Number S&S - 02 was complied with. [s. 20. (1)]

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 that will ensure that their "Residents - Zero tolerance for Resident Abuse Neglect", Index Number S&S - 02 is complied with., to be implemented voluntarily.

WN #3: 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 :

(A1)
1. The licensee failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

The following finding is related to Logs # 023848-18, #023984-18, and #023991-18

On a specified shift, on a specified date PSW #111 failed to complete and document resident care as they had slept for some portion of the their shift. In addition PSW #112 and #113 did not notify RN#114 that PSW #111 was sleeping.

According to the home's investigation documentation, RN#115 was alerted by subsequent shift staff that multiple residents were found lying or sitting in urine soaked and/or soiled briefs. One of these residents was dressed in unclean clothing. Despite being notified of the alleged neglect, RN #115 failed to immediately notify the Director and the licensee.

On a specified date, RPN #116 notified the DOC of the alleged neglect. Immediate actions included contacting resident Substitute Decision Makers and beginning an investigation. The Director was informed of the incident (s) that same day.

The Director was not informed of the incident(s) until a specified number of days after the incident was discovered. [s. 24. (1)]

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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On a specified date resident #014 was mistakenly given resident #015's medications by RPN #123. The RPN took both residents their medications at the same time. Resident #014 was administered resident #015's medications. The error was noted almost immediately, as following the administration of medication to resident #014, resident #015 alerted RPN #123 that the medication cup did not contain their medication.

The Nurse Practitioner (NP) #025 was notified and ordered monitoring of resident #014. The residents' family was also alerted and indicated that resident #014 is sensitive to a specified medication and that they may react negatively. Soon after the medication was administered resident #014 felt unwell and was transferred to hospital. The resident was monitored for a specified period and then returned to the home.

In efforts to prevent recurrence the home created alerts in their electronic Medication Administration Record (eMAR), as well as a reminder note placed directly on the eMAR tablet. The "eight rights" of medication administration were reviewed by the DOC and RPN #123. The RPN was also required to complete the Medication Practice Standards education module.

The licensee did not ensure that the prescribed medication was administered to resident #014. [s. 131. (1)]

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 that will ensure no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

Issued on this 14th day of December, 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by WENDY BROWN (602) - (A2)
Inspection No. / No de l'inspection :	2018_664602_0023 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007682-18, 008548-18, 020235-18, 023848-18, 023984-18, 023991-18, 025242-18, 028447-18 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 14, 2018(A2)
Licensee / Titulaire de permis :	The Corporation of the County of Frontenac 2069 Battersea Road, Glenburnie, ON, K0H-1S0
LTC Home / Foyer de SLD :	Fairmount Home for the Aged 2069 Battersea Road, R.R. #1, Glenburnie, ON, K0H-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Hirvi

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Corporation of the County of Frontenac, you are hereby required to comply with the following order(s) by the date(s) set out below:

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of December, 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by WENDY BROWN (602) - (A2)

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Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Ottawa Service Area Office