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
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2019	2019_664602_0014	031955-18, 033344-18	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): March 8, 11, 13, 14, 15, 21 & 22, 2019

Log# 031955-18 - regarding skin/wound care, personal support services, alleged staff to resident emotional abuse and medication management.
Log# 033344-18 - regarding above noted alleged staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), the Assistant Directors of Care, Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents. In addition the inspector reviewed resident health care records, the Falls Prevention/Management, the Prevention of Abuse/Neglect policies, and investigation documentation. The inspector also observed staff-resident and resident-resident interactions and resident care services.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	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. 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 :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c. 8, s. 20 (1).

The following finding relates to log #031955-18 and 033344-18.

On a specified date resident #001's Power of Attorney (POA) for Personal Care contacted the Director to review numerous concerns regarding resident care services. On a subsequent specified date, additional concerns regarding resident care and staff to resident emotional abuse were also reviewed.

The licensee's "Residents – Zero Tolerance for Resident Abuse and Neglect" policy outlines that resident rights shall be fully respected and promoted and include but are not limited to, the rights contained in the bill of rights. The objective of which was to support and protect the rights dignity and safety of all residents.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" is defined in O.Reg 79/10 as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Resident#001 had numerous heath related concerns and required total assistance with many activities of daily living.

On a specified date, resident #001 reported to Personal Support Worker (PSW) #103 that PSW #104 had made inappropriate statements toward them on a previous date. A Registered Practical Nurse (RPN) #105 was alerted and immediately attended the resident to assess and provide support. Resident#001 reviewed the statements made by PSW #104. RPN #105 advised the resident was upset by what had been said. On a specified date, additional confirmation that the statements had been upsetting for the resident was obtained.

An investigation was initiated and included multiple staff interviews, and staff, family and resident statements. The physician, police, family and the Director were notified of the incident. Investigation documentation found that PSW staff #104 made several

comments towards resident #001 and concluded that the allegation of emotional abuse was substantiated. PSW #104 indicated they were aware that what they said was unprofessional and wrong.

The licensee failed to ensure that PSW #104 complied with their "Residents – Zero Tolerance for Resident Abuse and Neglect" policy to support and protect the rights, dignity and safety of all residents. [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 to ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with, as per LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)., to be implemented voluntarily.

Issued on this 27th day of March, 2019

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

Original report signed by the inspector.