Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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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
Nov 20, 2019	2019_505103_0030	018179-19	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): November 12-14, 2019.

The following intake was inspected:
Log #018179-19 (CIS #M521-000025-19)-resident fall that resulted in injury.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), a Registered Nurse (RN), the Environmental Manager, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed the resident health care record, the licensee's investigation into the ceiling lift failure, correspondence received from the manufacturer, and the licensee's lift/transfer policy (#S&S-24, "Safety and Security-Use of Mechanical Lifts", revised May 16, 2019), and made observations of a ceiling lift.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 49 (1), the licensee failed to ensure the fall prevention and management program provided for strategies to reduce or mitigate falls including the use of equipment (mechanical lifts).

Specifically, staff failed to comply with the licensee's policy, #S&S-24, "Safety and Security-Use of Mechanical Lifts", revised May 16, 2019, which is a part of the licensee's fall prevention and management program. The policy defines the term "lift" as the procedure used to lift or carry the entire weight of a person. Resident lifts using resident lift devices will be performed by two trained staff and this includes ceiling track lifts.

On an identified date, resident #001 was given a tub bath by PSW #100 and sustained a fall that resulted in injuries to the resident. PSW #100 was interviewed and indicated they had completed the bath and raised resident #001 a specified distance above the floor of the tub using the ceiling lift. While the resident was suspended, the ceiling lift strap broke and resident #001 sustained injuries. PSW #100 indicated they were in the process of calling for a second staff member when the strap broke.

Staff failed to comply with the licensee's lift policy. [s. 8. (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 the licensee's policy, #S&S-24, "Safety and Security-Use of Mechanical Lifts", revised May 16, 2019, is complied with, to be implemented voluntarily.

Issued on this 20th day of November, 2019

[redacted]

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

Original report signed by the inspector.