Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jul 20, 2020	2020_765541_0003	005501-20, 007584-20, 010068-20	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

AMBER LAM (541)

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): July 7-10, 2020

The following logs were completed during this inspection:
Log #010068-20 Critical Incident M521-000012-20 related to the improper storage of a hazardous substance
Log #005501-20 CI M521-000007-20 related to a resident fall
Log #007584-20 CI M521-000009-20 related to a resident fall

During the course of the inspection, the inspector(s) spoke with the Director of care, the acting Assistance Director of Care, the Environmental Manager, Registered Nurses (RNs), Personal support workers (PSWs), and a resident. In addition the inspector reviewed resident health care records and relevant policies.

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

During the course of this inspection, Non-Compliances were issued.
2 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 that where this Act or 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. 48(1) every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's policy titled “Resident Falls”, policy #FALLS-03, which is part of the falls program.

On a specified date, resident #003 sustained a fall. A red incident report (progress note) entered on the date of the fall does not include vital signs for the resident.

On another specified date, resident #003 sustained another fall. The red incident report (progress note) does not include the time of the fall, whether the fall was witnessed, equipment used pre and post fall, aids used at the time of the fall, if aids not used at time of fall, where aids were located, foot wear at the time of the fall, whether the RN was notified, any complaints of dizziness including vital signs nor whether there were any medication changes in the past 4 weeks.

During an interview with RN #104 and an interview with the DOC, it was confirmed that these notes are considered the post-falls assessment.

Inspector requested policies related to the licensee’s falls program and received policy #FALLS-03 titled “Resident Falls” which states “The RPN/RN will complete an electronic resident red incident report, using the Standardized Falls Assessment Guideline (Form#158) for all falls and near miss falls.

Form #158 indicates, among other items that a falls red incident report is to include: Time of fall, where they fell, type of floor surface, whether the fall was witnessed, type of ADL they were doing before the fall, were they agitated when seen last, equipment used pre/post fall, aids used at the time of fall, if aids not used at time of fall where aids were located, any injury occurred, footwear at time of fall, any lower body extremity balance, gait and/or weakness pre/post fall, notify the RN of the resident fall, complaints of dizziness including vital signs and any medication changes in the past 4 weeks.

The licensee failed to ensure their falls policy was complied with as two post-fall assessments completed for resident #003 on two specified dates, did not contain all documentation as directed by policy #FALLS-03. [s. 8. (1) (a),s. 8. (1) (b)]

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 where this Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times.

According to Critical Incident M521-000012-20 and a progress note entered on a specified date, PSW #107 obtained a cleaning solution from the locked dirty utility room in order to clean a residents bed. PSW then went to obtain a care cart from outside a resident's room. When PSW #107 looked in resident's room, it was noted the resident required care. PSW #107 set the cleaning solution on the care cart and closed the resident's room to provide care. While in the room, resident #001 approached the care cart in the hallway and was witnessed by PSW #108 with the cleaning solution uncapped and near their mouth. It was unclear if resident drank the cleaning solution. Resident #001 was unable to answer questions appropriately due to diagnosis of dementia. Resident #001 was sent to hospital and returned to the home later the same day. Resident #001 was not harmed.

The licensee failed to ensure a hazardous cleaning solution was kept inaccessible to residents at all times. [s. 91.]

Issued on this 21st day of July, 2020

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

Original report signed by the inspector.