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
Nov 2, 2021	2021_873602_0032	011504-21, 011937-21, 012257-21, 015383-21	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

WENDY BROWN (602)

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 12-15, 19-21, 2021

The following inspections were completed:
Log #015383-21/ CIS#M521-000015-21 - regarding alleged staff to resident neglect.
Log #013003-21/ CIS#M521-000013-21 - regarding improper care.
Log #012257-21/ CIS#M521-000012-21 - regarding alleged staff to resident verbal abuse.
Log #011937-21/ CIS#M521-000011-21 - regarding a fall with injury.
Log #011504-21/ CIS#M521-000008-21 - regarding alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC), the Assistant DOC (ADOC)-Resident Services, the acting ADOC/Infection Prevention & Control (IPAC) lead, environmental services, a rehabilitation assistant, housekeeping staff, and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care & progress notes, medication administration records, investigation files, relevant policies and procedures, and made resident care & services, environmental services and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that three residents were protected from verbal abuse by a staff member.

A Personal Support Worker (PSW) was heard by a Registered Practical Nurse (RPN) speaking in a in a loud, belittling way with a resident they were assisting. Investigation documentation indicates that the RPN did not approach the PSW regarding the incident as they found the PSW to be dismissive and defensive. On the same shift the PSW told an RPN as they left a resident's room that the resident was a disaster; the resident became tearful and visibly upset. Later, the PSW brought the resident to the activities room to sit with another resident; the PSW told the co-resident not to worry as they don't have to babysit. In a third incident witnessed by the RPN, another resident asked the PSW where they were; the PSW told the resident in a blunt, scripted voice where they were; when the resident wasn't immediately re-oriented the PSW appeared frustrated, told the resident to calm down and walked away as the resident began to cry. Investigation interview notes indicate that the RPN explained they did not know how to address the incidents with the PSW in the moment and subsequently reported the three incidents to an RN who advised the RPN to email the on call Assistant Director of Care (ADOC) summarizing their concerns.

Ontario Regulation 79/10 indicates that verbal abuse includes any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature. Verbal abuse may diminish a resident's sense of well being, dignity and/ or self worth.

SOURCES: Critical Incident System (CIS) report, investigation documentation, Ontario Regulation 79/10, s. 2 (1)., Residents - Zero Tolerance for Resident Abuse and Neglect Policy, and interviews with the DOC, ADOC, PSW and other staff. [s. 19. (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 residents are protected from verbal abuse by staff, to be implemented voluntarily.

WN #2: 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 :

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

A resident was found by their family sitting in their wheelchair in their room having been incontinent. A PSW staff advised they had not assisted the resident with continence care earlier that shift as outlined in their care plan. In an interview with the ADOC, it was indicated that the subsequent investigation found that the PSW did not review the care plan as is the expectation of staff and did not assist the resident as a result. There is a risk of skin breakdown if a resident is left without continence care for a prolonged period of time.

SOURCES: CIS report, investigation documentation, resident progress notes, kardex & plan of care and interviews with the ADOC, PSW and other staff. [s. 6. (7)] [s. 6. (7)]

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 :

1. The licensee failed to ensure that alleged verbal abuse of three different residents was immediately reported to the Director.

An RPN sent an email to the on call ADOC detailing concerns regarding alleged verbal/emotional abuse of three residents by a PSW. The email was forwarded to ADOC two days after the incidents.

The DOC and ADOC confirmed that their investigation found that the PSW was inappropriate verbally with the three residents and that the incidents were not immediately reported to the Director.

SOURCES: CIS report, investigation documentation and interviews with the ADOC, DOC and other staff. [s. 24. (1)]

Issued on this 5th day of November, 2021

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

Original report signed by the inspector.