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

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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
Oct 27, 2021	2021_873602_0033	016416-21	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): October 12-15, 19-21, 2021

The following inspection was completed:
Log #016416-21 - regarding alleged staff to resident neglect.

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, and family member(s).

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, and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a residents right to privacy was respected and promoted while providing care

A family arrived at the home and found the resident partially unclothed in their room with the door open. The incident was reported and an investigation was completed. A Personal Support Worker (PSW) staff indicated they had been caring for another resident when they heard a loud noise in the resident's room. The PSW started to assist the resident with personal care when they had to leave to complete the care for the resident they were attending to initially. The PSW asked another PSW to complete the care for the resident. The second PSW indicated they had gone to gather required supplies when the family arrived. Neither PSW staff closed the resident's door to afford them their privacy.

Sources: Critical Incident System report, investigation documentation, resident progress notes, kardex & plan of care and interviews with family, the Assistant Director of Care, the Director of Care and other staff [s. 3. (1) 8.]

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.