Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: December 5, 2023
Inspection Number: 2023-1545-0005
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the County of Frontenac
Long Term Care Home and City: Fairmount Home for the Aged, Glenburnie

Lead Inspector	**Inspector Digital Signature**
Ashley Bernard-Demers (740787)	Ashley F Bernard-Demers Digitally signed by Ashley F Bernard-Demers Date: 2023.12.06 12:20:23 -05'00'

Additional Inspector(s)
Wendy Brown (602)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 - 24, and 27 - 29, 2023

The following intake(s) were inspected:

- Intake: #00097094 - [CI M521-000028-23] Resident to resident alleged abuse.
- Intake: #00097584 - [CI M521-000029-23] Resident to resident alleged abuse.
- Intake: #00098912 - Complaint about alleged improper treatment of a resident.
- Intake: #00099108 - Complaint about the home not meeting the dietary needs

of a resident.
- Intake: #00101246 - [CI M521-000033-23] Fall of a resident with injury.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (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.

The licensee has failed to ensure that potential improper care was reported for a resident after an incident in which the resident's responsive behaviours led to the use of inappropriate methods to assist with management of their behaviours.

Sources: Review of the Ministry of Long-Term Care's Critical Incident System Report database, and staff interviews.
[740787]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that potential abuse was reported for a resident after an incident in which the resident felt scared and threatened.

Sources: Review of the Ministry of Long-Term Care's Critical Incident System Report database, review of the home's policy, and staff interviews.
[740787]

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,

(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences;

The licensee failed to ensure that a resident was offered a specified diet choice for a meal. Staff interviews revealed that typically there is no second special diet option available.

Sources: Resident progress notes, plan of care - diet, menu cycle-special diet sheet, and interviews with resident and staff.

[602]

WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 7.
Prohibited devices that limit movement
s. 121 7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

The licensee has failed to ensure that a prohibited device was not used to limit the movement of a resident.

Sources: Resident progress notes, meeting notes, and staff interviews.

[740787]

WRITTEN NOTIFICATION: Emergency plans

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. iv.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,
   iv. violent outbursts,

The licensee has failed to ensure that a policy was complied with during a situation of potential or actual threat to a resident's own safety, the safety of others or the safety of property.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols were developed for emergency plans and ensure they were complied with.

Specifically, staff did not comply with the licensee's Code White policy during an incident with a resident.

Sources: Code White policy, and staff interviews.

[740787]

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