Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 16, 2013	2013_179103_0015	O-000156-13	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): April 12, 15, 2013

During the course of the inspection, the inspector(s) spoke with a Registered Nurse, the Director of Resident Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed the resident health care record and the home's policy on abuse.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 20. Policy to promote zero tolerance

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Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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1. The licensee has failed to comply with LTCHA, 2007 s. 20 (2) whereby the policy to promote zero tolerance of abuse and neglect does not comply with requirements in the regulations.

The home's policy on abuse " Residents-zero tolerance for resident abuse and neglect S&S-02" states, The Director of Resident Care and/or Administrator shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are notified:
a) Immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well being
b) within 24 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

O. Regs 79/10 s. 97 (1) (b) require an alleged, suspected or witnessed incident of abuse or neglect of a resident, that fall under this category, be reported within twelve hours, not twenty four hours. [s. 20. (2)]

WN #2: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to comply with LTCHA, 2007 s. 24 (1) whereby an incident of alleged abuse was not immediately reported to the Director.

On a specified date, an alleged incident of physical abuse was reported to have occurred between a staff member and Resident #1 who has a cognitive impairment. The Administrator and the Registered Nurse (RN) S#100 conducted an immediate investigation which included sending the accused staff member home and reviewing the physical abuse algorithm. At that time, the resident had no evidence of injuries or pain, and according to the Administrator, it was determined a physical abuse had not occurred and the home would manage the incident internally.

On the following evening, RN S#100 noted fresh bruising on Resident#1 and believed this was related to the previously reported alleged abuse. The RN failed to report this information to the Administrator until the next morning. The Administrator immediately reported the alleged abuse to the Director upon receiving this information. The RN failed to immediately report information that supported an allegation of physical abuse to the Administrator which delayed the report to the Director. [s. 24. (1)]

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Issued on this 16th day of April, 2013

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