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
Jan 22, 2020	2020_779641_0002	023898-19	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

CATHI KERR (641)

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): January 16, 17, 20, 21, 2020.

This inspection was conducted in reference to intake log #023898-19 related to a complaint received concerning resident #002.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Medical Director, family and the resident.
During the course of the inspection, the Inspector reviewed the resident's health care record and the licensee's procedures related to notification of substitute decision-makers.

The following Inspection Protocols were used during this inspection:
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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

This inspection was conducted in reference to intake log #023898-19 related to a complaint received concerning resident #002. During an interview with Inspector #641 on January 16, 2020, the complainant advised that they had joint Power of Attorney (POA) with their sibling and that only the sibling was being notified or consulted by the licensee of changes to the resident's care. The complainant stated that when resident #002 was admitted to the home, of having agreed to allow their sibling to be the primary contact for the resident, who would in turn then notify the complainant. The complainant specified not always being informed by the other POA so they had notified the licensee on a specified date, that they revoked the original agreement. The complainant indicated to the licensee that they would like to be the primary contact and if this was not possible, then both POA's were to be notified as per the legislation. The complainant stated being advised by the licensee that their practice was to only notify one person per resident and would therefore only be able to notify the POA who was the existing primary contact, unless the two POAs could agree on the change.

During an interview with the Inspector on January 17, 2020, the Director of Care indicated that the procedure in the home when there was more than one POA for a resident, was that they would establish on admission, who would be the one person to contact. This would be agreed upon by the joint POA's. The DOC stated that the reason for this was to protect the resident in case of disagreements between the POA's and not to withhold information from the other POA. The DOC advised being aware that the complainant had given notification to the home on a specified date, that they would no longer accept the original agreement to not require notification from the licensee of changes in resident #002's care. The complainant requested that the licensee notify both POA's of anything involving the resident. The DOC stated that the licensee had continued to follow their policy to only notify the one POA, who was the primary contact of resident #002 and not to notify both POA's.

The licensee failed to ensure that both of resident #002's substitute decision-makers were given an opportunity to participate fully in the implementation of the resident's plan of care. [s. 6. (5)]

Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.