Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Feb 4, 2021	2020_664602_0025	017433-20, 023613-20	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): January 25 - 29, 2021

The following inspections were completed:
Log# 023613-20 - regarding right to privacy, end of life care and reporting & complaints.
Log# 017433-20 - regarding communication and plan of care.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Directors of Care (ADOC), the Director of Care (DOC), the Infection Prevention & Control (IPAC) lead, the manager of environmental services, housekeeping staff and the Administrator.

In addition, the inspector reviewed resident health care records; including plans of care, medication administration records, weight monitoring, physician orders & progress notes, relevant policies & procedures, investigation documentation, and made resident care & service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 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 fully respect and promote a resident's right to be afforded privacy in caring for their personal needs.

A resident was in their wheelchair with their lower half undressed; they were to be transported to the tub room for their bath when the PSW staff had to assist with another resident's need for immediate attention. The resident was situated at the nursing station. A blanket was put in place to afford the resident privacy while the PSW assisted with the other resident's care. The resident removed the blanket unintentionally exposing themselves to view by co-residents, staff and visitors.

Sources: Long-term Care Critical Incident System report, resident clinical records, investigation documentation, observations on all resident care units and interviews with the Director of Care (DOC), two Assistant DOCs, personal support workers (PSW) and other staff. [s. 3. (1) 8.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents’ linens are changed at least once a week and more often as needed,
(ii) residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the process to report and locate resident's lost dentures was implemented.

A family contacted the Ministry of Long Term Care to advise that a resident's dentures had previously gone missing and were not replaced. A subsequent review of the home's missing items policy and procedure indicates that when missing items are reported a search is conducted, unit staff are alerted, and contact with laundry services is completed. If the item cannot be located the issue is forwarded to an ADOC who connects with family as to next steps. A Lost & Found form is to be provided to the family or resident for completion and then forwarded to the manager of environmental services. Interviews with multiple staff revealed they were not aware of the form or the need to provide it to the family and/or assist with it's completion to initiate an investigation. The resident's dentures were not located or replaced.

Sources: The Intake Log, the Laundry-Missing Clothing/Lost & Found policy and interviews with two Assistant DOC's, PSWs and other staff. [s. 89. (1) (a) (iv)]

Issued on this 5th day of February, 2021

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

Original report signed by the inspector.