

**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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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 6, 2021	2021_898541_0004	009033-21	Critical Incident System

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**Licensee/Titulaire de permis**

The Corporation of the County of Frontenac  
2069 Battersea Road Glenburnie ON K0H 1S0

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**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

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

AMBER LAM (541)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 30 and July 2, 2021**

**A log related to an incident of alleged staff to resident abuse was inspected during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, Registered Practical Nurses, Personal Support Workers and Housekeepers. In addition the inspector conducted a tour of the home, observed a meal service, observed temperatures throughout the home and reviewed the licensee's policy titled "Zero Tolerance for Resident Abuse and Neglect."**

**The following Inspection Protocols were used during this inspection:**  
**Infection Prevention and Control**  
**Prevention of Abuse, Neglect and Retaliation**  
**Responsive Behaviours**  
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

On June 30, 2021 a lunch meal was observed on 2 south. During that observation, no resident hand hygiene was performed upon completion of the meal. Inspector interviewed the RPN who had assisted multiple residents out to the dining room and they confirmed they had not assisted the residents' to perform hand hygiene. The IPAC lead indicated it is the expectation that residents' hands are cleaned before and after meals.

The failure to follow IPAC practices presents a risk to residents related to the possible spread of disease-causing organisms that may have been on their hands.

Sources: Direct observations, interviews with RPN #105 and IPAC lead. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**Issued on this 8th day of July, 2021**

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

**Original report signed by the inspector.**