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
Feb 24, 2022	2022_902622_0003	017024-21, 020583-21, 000435-22	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

HEATH HEFFERNAN (622)

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): February 7, 8, 9, 10, 11, 17, 18, 2022

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #017024-21, CIS #M521-000016-21, was related to alleged staff to resident neglect.
Log #020583-21, CIS #M521-000020-21, was related to alleged resident to resident abuse.
and Log #000435-22, CIS#M521-000001-22, was related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC) X3, Manager of Environmental Services, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Support Ontario PSW (BSO), a housekeeper and the residents.

Also during the course of the inspection, the inspector reviewed resident health records, the licensee's policy and procedure specific to; Safety and Security - Zero Tolerance for Resident Abuse and Neglect - Index Number: S&S-02, Infection Prevention and Control (IP&C) - Resident Visitation during COVID-19 - Index Number: IP&C-29, revised: January 28, 2022, Essential Caregiver and Visitor Policy During COVID-19 - Index Number: IP&C-31, revised: February 7, 2022, Contingency Plan for Control of Communicable Disease Outbreak - Index Number: IP&C-16, the Respiratory Algorithm, and made observations of the environment, resident care and services, staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that specific assessments set out in the responsive behaviours plan of care were completed for three residents as specified in the plan.

Physician's orders were made for three residents, that specific assessments were to be completed within a certain time frame from the date of each order. For each resident, the specific assessments were not completed on multiple dates.

The Assistant Director of Care stated that the plan of care included all resident health records including physician orders and the specific assessments. The plan of care was not followed for the three residents when the specific assessments were not completed as ordered.

Sources: Physician order sheets, specific assessments, the Assistant Director of Care, and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 all staff participated in the implementation of the Infection Prevention and Control program.

The Respiratory Algorithm from the Outbreak Management binder stated that for ill residents, to implement droplet /contact precautions which included posting the precaution sign on the resident's door.

Two resident rooms were observed to have yellow isolation stations on the doors, garbage and soiled linen stands set up. There were no signs indicating the type of isolation, the type of PPE required or to report to the nurse's station prior to entering the rooms.

Assistant Director of Care (ADOC) stated that when the residents had displayed respiratory or COVID-19 symptoms, the two resident rooms should have had signage on or beside the doors.

Sources: Initial tour observations, the licensee's policy, and procedure; Contingency Plan for Control of Communicable Disease Outbreak, Index Number: IP&C-16, the Respiratory Algorithm, interview of the Assistant Director of Care and other staff. [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 program, to be implemented voluntarily.

Issued on this 25th day of February, 2022

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

Original report signed by the inspector.