Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
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Original Public Report

Report Issue Date: January 24, 2023	
Inspection Number: 2023-1545-0001	
Inspection Type: Critical Incident System	
Licensee: The Corporation of the County of Frontenac	
Long Term Care Home and City: Fairmount Home for the Aged, Glenburnie	
Lead Inspector Heath Heffernan (622)	**Inspector Digital Signature** Heath Heffernan Digitally signed by Heath Heffernan Date: 2023.01.24 13:54:44 -05'00'
Additional Inspector(s) Polly Gray-Pattemore (740790) Wendy Brown (602)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 4 - 6, 9- 13 and 16 - 19, 2023.

The following intake(s) were inspected:
• Critical Incident Intakes: #00001167/CI: M521-000008-22, #00001649/CI: M521-000011-22, #00003342/CI: M521-000013-22, #00016094/CI: M521-000031-22, #00015100/CI: M521-000028-22, related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.
• Critical Incident intake: #00013644/CI: M521-000026-22 related to alleged staff to resident physical abuse.
• Critical Incident intake: #00015298/CI: M521-000029-22 related to a complaint of resident care and services.

The following intakes were completed in this inspection #00002833/CI: M521-000018-22, #00006408/CI: M521-000016-22 related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Reporting and Complaints
Pain Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2.

Rationale and Summary:
Review of the licensee's response to a complaint related to a resident's care and services indicated that the response did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

During an interview, the Assistance Director of Care (ADOC) acknowledged that the response provided to the complaint related to a resident's care and services did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

There was risk to the residents related to the Ministry's toll-free number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2 not being included in the response to a complaint.

Source: Review of Critical Incident System report (CI) M521-000029-22; the licensee's response provided to the complaint; and interview with the ADOC.
[740790]

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