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
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Original Public Report

Report Issue Date: October 26, 2023	
Inspection Number: 2023-1545-0004	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Frontenac	
Long Term Care Home and City: Fairmount Home for the Aged, Glenburnie	
Lead Inspector Dee Colborne (000721)	**Inspector Digital Signature** Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2023.10.31 10:07:24 -04'00'
Additional Inspector(s) Shevon Thompson (000731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6, 7, 8, 14, 15, 2023
The inspection occurred offsite on the following date(s): September 11, 12, 2023

The following intake(s) were inspected:

- Intake: #00093765 -Falls that resulted in a significant change in condition.
- Intake: #00094655 -Resident to resident alleged abuse.

Amber Lam (541) was present during this inspection.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Care and Support Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident had had multiple falls and was no longer able to ambulate independently thus required the use of a wheelchair.

Rationale and Summary:
Inspector observed a resident on a specified date and noted the resident to be using a wheelchair.

A review of the resident's electronic record indicated there was no noted reassessment of the resident's care needs when the resident was no longer able to walk and required the use of a wheelchair.

Review of the resident's current care plan did not show an intervention for the use of a wheelchair.

In an interview with the Acting Assistant Director of Care (AADOC) they acknowledged that the home used the RAI MDS (Resident Assessment Instrument-Minimum Data Set) initially, quarterly, and when there is a significant change in the resident's condition. The ADOC #111 reviewed the assessments in the resident's electronic documentation and confirmed that a reassessment of the resident had not been completed when their care needs changed.

In an interview with RPN #114, they stated the RAI MDS was done every three months and when there was a significant change in the resident's condition.

A resident was placed at risk of not having their care needs met since the reassessment of their care needs was not completed when the resident was no longer able to walk and required a wheelchair.

Sources: Resident electronic record, PointClickCare- MDS Assessment, Resident Care Plan, Observations Interview with Acting Assistant Director of Care (AADOC) #111, and interview with RPN #114

[000731]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that the Director was informed immediately of an incident regarding resident to resident alleged abuse that caused an injury to resident.

Rationale and Summary:
On a specified date, an altercation ensued between two residents resulting in an injury to one of the residents. Progress notes of both residents indicated that the altercation occurred resulting in bruising to two fingers of a resident's hand.

The Critical Incident Report (CIR) submitted to the Director, indicated the alleged resident to resident abuse occurred on a specified date in August. The incident was not reported to the Director until a later specified date in August.

In an interview with the Assistant Director of Care (ADOC) #106, they confirmed that the home should have immediately reported the incident to the Long-Term Care homes after hours line on a specified date in August.

Failing to ensure that the Director was informed immediately of this incident potentially placed the residents at risk of not receiving appropriate follow-up.

Sources: Critical Incident Report, resident's progress notes, Interview with ADOC #106.
[000721]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home (LTCH) to carry out every operational directive, every directive was complied with.

Specifically, the licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not complete weekly IPAC audits while the home was in an outbreak from August 14, 2023 to September 5, 2023.

In accordance with section 1.1 of the Minister's Directive: Covid-19 response measures for long-term care homes, licensees shall ensure measures are taken to prepare for and respond to a COVID-19 outbreak, including ensuring the development and implementation of a COVID-19 Outbreak Preparedness Plan. This plan must, among other things, include conducting regular IPAC audits in accordance with the Covid-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended. When a home is in outbreak, IPAC audits must be completed weekly. At minimum, homes must include in their audit the PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

Rationale and Summary:

Review of Critical Incident Report # M521-000024-23 indicated that on August 14, 2023, public health declared COVID-19 outbreak.

Record review of the home's 2023 Non-Outbreak COVID-Self Assessment Audits file indicated the PHO's COVID – 19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes was completed on August 17, 2023. There were no more weekly audits completed after August 17, 2023. In an interview with the IPAC Lead #107 and the Director of Care #108, they stated the IPAC Self-audits, following the PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes, had been conducted at the start of the outbreak.

In a further interview with the Director of Care #108, they stated that after a review of the records for the IPAC Self-Audits it was noted the audit was done at the start of the outbreak but not again during the outbreak.

Failure to ensure the weekly completion of the Infection Prevention and Control program Self-audits, while the home is in outbreak, puts the home at risk for not being able to adequately respond to changes in the COVID-19 outbreak.

Source: Interviews with IPAC Lead #107 and Director of Care #108, Fairmont HFA file: 2023 Non-Outbreak COVID-Self Assessment Audits, MLTC Critical Incident System Report #M521-000024-23

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WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen , the resident was assessed and that post-fall assessments were conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary:
In a review of a resident's health record it was noted that a resident had several falls on a specified date in July. It was further noted that on a specified date in July only one Post Fall Assessment was completed using the clinically appropriate assessment tool specifically designed for falls.

Review of progress notes showed no post fall assessment completed for four of the five falls.

The home's Falls Prevention & Management program - Resident Falls policy, states "Once the resident has been assessed and assisted off the floor, the fall shall be documented by the first registered staff member attending the fall. The RPN/RN will document all details of the fall using PointClickCare (PCC) – Risk Management, which will include the completion of an Initial Post Fall Assessment progress note. Following the template of the progress note, the registered staff will capture their post fall assessment."

In an interview with ADOC #106, when asked about the falls a resident had on a specified date in July, they stated that the nurse that was working grouped all falls together in one note.

In an interview with RPN #114, they stated that the home's expectation of staff is to complete an Initial Post Fall Assessment after every fall.

Failure to ensure the completion of the resident's Post Fall Assessments place the resident at increased risk for falls and injury.

Source: Interview with RPN #114, ADOC #106, Fairmont Home - Falls Prevention & Management program - Resident Falls policy, Resident's electronic record PointClickCare progress notes and Risk Management System.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

A) The licensee failed to ensure that for each resident, demonstrating responsive behaviours, that the

behavioural triggers for the residents are identified.

Rationale and Summary:
Review of a resident plan of care did not clearly identify triggers in regards to the resident's physical aggression towards other residents and staff.

Review of a resident's progress notes identified other incidents of physical aggression towards other residents prior to the alleged abuse incident on a specified date in August.

During an interview with the Behavioural Support of Ontario staff, (BSO) #102, they confirmed that the resident was discharged from Seniors mental health program and is not being followed by BSO at present to identify triggers.

During an interview with PSW #105, they confirmed that once BSO has identified triggers, they are to be placed in the residents' plan of care. They confirmed they were not aware of the physical altercation between the two residents on a specified date in August.

During an interview with PSW #100, they stated the care plan was not updated to reflect managing responsive behaviours after the incident between the residents on a specified date in August. PSW #100 also stated that triggers to manage responsive behaviours should be noted on the care plan on point click care, thru daily report, emails, and that it is also communicated thru staff.

During an interview with RPN #103, they confirmed triggers should be noted on the resident's plan of care and felt that if someone was in a resident "face" they could easily become aggressive.

ADOC's #106 and ADOC #111 were able to confirm that there were no identifying triggers in regards to physical aggression on a resident plan of care.

Failure to ensure triggers are identified on the plan of care, places both residents and staff at risk for not being able to effectively manage responsive behaviours.

Sources: Resident's progress notes, plan of care, interviews with BSO #102, ADOC #106 and #111 and other staff.
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B) The licensee failed to ensure that for each resident, demonstrating responsive behaviours, that the behavioural triggers for the residents are identified.

Rationale and Summary:
Review of a resident's plan of care did not clearly identify triggers in regards to physical/verbal aggression towards other residents and staff.

Review of a resident's progress notes identified several incidents of physical aggression towards other residents and staff prior to the physical aggression between two residents on a specified date in August.

During an interview with BSO #102, they confirmed that the resident was being followed by BSO since a residents admission. They confirmed that no follow up was done in regard to the alleged abuse on a specified date in August, but that they were aware of the incident and it was left for them to review.

During an interview with PSW #100, they stated the care plan was not updated to reflect triggers in managing responsive behaviours after the alleged physical abuse between two residents on a specified date in August. PSW #100 further stated that triggers to manage responsive behaviours should be noted on the care plan on point click care, thru daily report, emails, and that it is also communicated thru staff.

During an interview with RPN #103, they confirmed triggers should be noted on the resident's plan of care.

During interviews with the ADOC's #106 and ADOC #111, they were able to confirm that there were no identifying triggers in regards to physical aggression on a resident's plan of care.

Failure to ensure triggers are identified on the plan of care, places both residents and staff at risk for not being able to effectively manage responsive behaviours.

Sources: Residents progress notes, plan of care, interviews with BSO #102, ADOC #106 and #111 and other staff.
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WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

A) The licensee failed to ensure that, for each resident, demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

Rationale and Summary:
Review of a resident plan of care did not identify any assessments and interventions in regards to the resident physical aggression towards other residents and staff.

Review of a resident progress notes identified several incidents of physical aggression towards other residents prior to alleged abuse on a specified date in August. No referrals were made to the Behavioural Support of Ontario staff, (BSO), so that an assessment could be made regarding a resident's aggressive behaviours.

An interview with BSO #102 confirmed that the resident was discharged from Seniors mental health program and is not being followed by BSO at present. They confirmed that no follow up/assessment was done in regard to the incident between two residents on a specified date in August.

During an interview with RPN #103, they stated they are unsure of how to make referrals to BSO for follow up, and unsure if one was made the evening of the physical altercation between two residents.

During an interview with RN #104, they confirmed that referrals are to be sent to BSO via point click care or via emails for any new or unusual behaviours. They were unable to identify how staff would know that BSO did their follow up/assessment.

During an interview with the ADOC #106, they confirmed the expectation is for BSO to assess and reassess residents with responsive behaviours and to document. They advised that BSO staff should be reading progress notes and that would be a cue for the BSO to follow up and see the resident and to document outcome. ADOC #111 also confirmed that a resident is not being followed by BSO and was discharged from Seniors Mental Health(SMH) early in 2023.

During interviews with the ADOC's #106 and #111, they both confirmed that referrals are to be made to BSO for any responsive behaviours for assessment.

Sources: Critical Incident Report, Resident's plan of care, progress notes, Interviews with BSO #102, RN #104, ADOC's #106 and #111 and other staff.
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B) The licensee failed to ensure that, for each resident demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Rationale and Summary:
Review of a resident's plan of care had no specific focus or identifying assessments and interventions in regards to physical aggression towards other residents and staff.

Review of a resident progress notes identified several incidents of physical aggression towards other residents and staff prior to the incident on a specified date in August. Progress notes documented from BSO staff identified that there was no noted assessment or reassessment conducted regarding a residents physically aggressive behaviours.

Interview with BSO #102 confirmed that the resident was being followed by BSO since admission. They confirmed that no assessment was completed regarding the physical altercation between two residents on a specified date in August, but that they were aware of the incident.

Interview with PSW #105 confirmed that once BSO has trialed interventions, they are to be placed in the residents' plan of care. They confirmed that they were not aware of the physical altercation between two residents.

Interview with RPN #103 confirmed they are unsure of how to make referrals to BSO and unsure if one was made the evening of the physical altercation between two residents.

Interview with RN #104 confirmed that referrals are to be sent to BSO via point click care or via emails for any new or unusual behaviours. They were unable to identify how staff would know that BSO did their follow up/assessment.

ADOC #106 and ADOC #111 confirmed the expectation is for BSO to follow up regarding incidents and to also document their assessments. ADOC #111 further confirmed that the homes expectations are for BSO to be monitoring residents with behaviours, who are in the list for seniors mental health, at least weekly, and other residents are reviewed within a couple of weeks of the behaviour.

Failure to take action in regards to assessments and reassessments for responsive behaviours, places all residents at risk of harm.

Sources: Residents progress notes, plan of care, interviews with BSO #102, ADOC #106 and #111 and other staff.
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