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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 31, 2024	
Inspection Number: 2024-1545-0003	
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 Polly Gray-Pattemore (740790)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17, 2024 and May 21-23, 2024.

The following intake(s) were inspected:

- Intake: #00114874/CI#M521-000014-24 was related to alleged resident to resident abuse.
- Intake: #00115049/CI#M521-000015-24 was related to alleged resident to resident abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to comply with resident monitoring protocols for a resident. In accordance with O. Reg. 246 / 22, s. 11 (1) (b) the licensee shall ensure that any plan or strategy required under the program is complied with. Specifically, staff did not comply with the licensee's policy Residents-Responsive Behaviours that stated that all staff shall ensure completion of screening tools (Dementia Observation System (DOS), etc.) when indicated.

Rationale and Summary:
A review of the Critical Incident System (CIS) report M521-000015-24, indicated that on a day in April, 2024 there was an alleged physical abuse by a resident toward another resident.
A review of the resident's prescriber orders indicated that on a day in April, 2024 there was an order for a Behaviour DOS.

A review of the resident's DOS screening tool from a day in April to a day in May, 2024 showed that there were missing entries.

During an interview with staff #107, they acknowledged that the resident's DOS had missing entries, should have been completed, and staff did not follow the Resident-Responsive Behaviours policy related to completion of the DOS screening tool, when indicated.

Sources: CIS M521-000015-24 report; licensee's policy titled 'Residents-Responsive Behaviours', last revision November 18, 2022; resident DOS and prescriber orders; and interview with staff #107.
[740790]

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