



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance

Division

Performance Improvement and Compliance Branch

**Division de la responsabilisation et de la
performance du système de santé**

**Direction de l'amélioration de la performance et de la
conformité**

Ottawa Service Area Office

347 Preston St, 4th Floor

OTTAWA, ON, K1S-3J4

Telephone: (613) 569-5602

Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa

347, rue Preston, 4^{ème} étage

OTTAWA, ON, K1S-3J4

Téléphone: (613) 569-5602

Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 9, 10, 11, 12, 2012	2012_179103_0003	Critical Incident

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses, Registered Nurses, the Assistant Director of Care and the Director of Care.

During the course of the inspection, the inspector(s) reviewed resident health care records, critical incidents and mandatory reports. This inspection was conducted for the following log numbers: O-000471-12, O-000478-12, O-000791-12.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 23 (1) (a) whereby an alleged abuse of a resident was not immediately investigated.

An alleged incident of abuse was witnessed on an identified date. The investigation into this incident was not initiated by the home until the following day.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 24 (1) whereby the Director was not immediately notified of an incident of alleged abuse.

An alleged incident of abuse was witnessed on an identified date. The incident was not reported to the Director until the following day.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 30 (2) whereby resident assessments were not documented.

The Director of Care was interviewed and advised post fall assessments are documented in the resident progress notes and/or in incident reports within Gold Care which is completed after each resident fall.

Resident #1 and #3 sustained falls on identified dates. Their progress notes were reviewed and did not indicate any assessment for injuries post fall. The Gold Care incident reports were reviewed and indicated the residents had been assessed but there were no details documented in regards to the assessment performed. Staff failed to document the post fall assessment related to injuries.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 98 whereby the police were not immediately notified of an alleged abuse.

An alleged incident of abuse was witnessed on an identified date. The incident was not reported to the police until the following day.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
 - i. names of any residents involved in the incident,
 - ii. names of any staff members or other persons who were present at or discovered the incident, and
 - iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
 - i. what care was given or action taken as a result of the incident, and by whom,
 - ii. whether a physician or registered nurse in the extended class was contacted,
 - iii. what other authorities were contacted about the incident, if any,
 - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
 - v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
 - i. the immediate actions that have been taken to prevent recurrence, and
 - ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 107 (4) 2 whereby a description of the individuals involved in an incident were not included in a critical incident submission.

A critical incident was submitted by the home to report a resident injury resulting in transfer to hospital as a result of a fall. The critical incident failed to identify the name of the resident involved in the incident.

2. The licensee has failed to comply with O. Reg 79/10 s. 107 (3) whereby the Director was not notified within one business day after the occurrence of the following incidents.

Resident #3 sustained a fall on an identified date and was sent to hospital for assessment of injuries. The Director was advised for the first time eight days later.

Resident #1 sustained a fall on an identified date and was sent to hospital for assessment of possible injuries. The Director was advised for the first time six days later.

An unidentified resident sustained a fall on an identified date and was sent to hospital for assessment of injuries. The Director was advised for the first time two days later.



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Issued on this 12th day of October, 2012

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

A handwritten signature in black ink, appearing to read "Darlene Murphy".