Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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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
Jul 29, Aug 2, 9, 2011	2011_048175_0010	Complaint

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

Long-Term Care Home/Foyer de soins de longue durée

ROSEBRIDGE MANOR
131 Roses Bridge Road, R. R. #2, Jasper, ON, K0G-1G0

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurse, Charge, Days, Registered Practical Nurse, Days

During the course of the inspection, the inspector(s) Reviewed the Power of Attorney Document and the resident's health record

The following Inspection Protocols were used in part or in whole during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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.) 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 subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits sayants :

1. Nursing progress notes indicated that the following was noted on an identified resident's health record: " Altered ability to swallow: The resident had an episode of choking at lunch. Able to clear airway unassisted... Modified minced diet ordered x 1 week to assess ability to swallow." No notation that Substitute Decision Maker was notified of this change in the resident's health status or plan of care related to diet change.

2.Power of Attorney Agreement indicates Designated Substitute Decision Maker (SDM) for resident is identified.

3.The day after the choking incident and the resident's diet was changed to modified minced x 1 week, Registered Practical Nurse (RPN),documented on the resident progress notes that the resident's SDM called and expressed concerns regarding his condition- "that he is not talkative and also that he seems to have difficulty eating his meals..." There was no documentation of any attempt by the RPN to inform the SDM of the resident's choking incident the previous day or to give the person any opportunity to to participate in the development or implementation of changes made to the resident's plan of care.

4.The resident's SDM confirmed with the Inspector of not being informed of the resident choking when it occurred and not being told that the resident's diet had been changed to minced by Registered Nurse, who apologised for not telling the SDM sooner.

5.Documentation of referral by the Registered Dietitian in the home, indicates the resident had a choking incident and was trialled on total minced diet for one week. Tolerance of minced diet good-intake varies with occasional refusal but is usually 100%. No choking during trial. Plan- change diet to minced texture. There was no documentation of any attempts by the Dietitian to give the resident's SDM an opportunity to participate in the development or implementation of changes made to the resident's diet, in response to the choking episode.

Issued on this 17th day of August, 2011

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

B. Thompson