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: December 27, 2023
Inspection Number: 2023-1011-0009
Inspection Type: Critical Incident Follow up
Licensee: 2629693 Ontario Inc.
Long Term Care Home and City: Sarsfield Colonial Home, Sarsfield

Lead Inspector	**Inspector Digital Signature**
Manon Nighbor (755)	Manon Nighbor Digitally signed by Manon Nighbor Date: 2024.01.03 10:26:25 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 19-21, 2023.

The following intake(s) were inspected:

- Intake: #00100458 - Follow-up #: 2 - O. Reg. 246/22 - s. 123 (3) (a), related to medication management
- Intake: #00100459 - Follow-up #: 3 - O. Reg. 246/22 - s. 12 (1), related to doors in the home.
- Intake: #00099394 Critical Incident System (CIS) #0943-000008-23, related to a fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1011-0003 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Manon Nighbor (755)

Order #002 from Inspection #2022-1011-0001 related to O. Reg. 246/22, s. 12 (1) inspected by Manon Nighbor (755)

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

Medication Management
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home -Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict

unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On December 19, 2023, the utility room doors on three floors were found unsupervised, unlocked, and one of the doors was ajar. There were garbage, dirty laundry, cleaning and hand disinfecting products in the rooms. A staff member confirmed that the utility doors were left unlocked.

The Director of Care (DOC) and the Nutritional Services Manager confirmed that the staff received education related to closing and locking nonresident care area doors. Since the incident they have posted signage on the door to remind staff to lock the doors. The task of verifying that the doors are kept closed and locked was added to the Behavioral Support Ontario staff member's job description.

As such, leaving utility room doors unlocked increased the risk for residents to enter when not supervised and potentially injury themselves.

Sources: Inspector's observations, interviews with staff member, DOC and Nutritional Food Service Manager.
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