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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire x ☐ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 1 and 2, 2010	2010-136-9521-01NOV111328	Critical Incident O-001347

Licensee/Titulaire
The Corporation of the County of Frontenac, 2069 Battersea Road, Glenburnie, ON K0H 1S0 Fax 613 546 0489

Long-Term Care Home/Foyer de soins de longue durée
Fairmount Home , 2069 Battersea Road, Glenburnie, ON K0H 1S0 Fax 613 546 0489

Name of Inspector(s)/Nom de l'inspecteur(s)
Delores Mac Donald (136)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Inspection on a Critical Incident Report regarding a resident...

During the course of the inspection, the inspector spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), three Registered Practical Nurse (RPN), two Registered Nurses (RN) , a Registered Dietitian (RD), the RAI Coordinators, five Personal Support Workers (PSW),and two Food Service Workers (FSW). In addition, introduced self to the resident, several other residents and a family member who was in the dining room during the meals observed.

The inspector went to interview the Nutritional Manager and found that the home did not have one at the time of this visit.

The inspector reviewed all documentation around the Critical Incident including the home' s and police investigations The inspector reviewed the care records of the resident including Care Plans, Nutritional Reviews and Weight Records.

Two meals served to the resident were observed.

The following Inspection Protocols were used during this inspection: Prevention of Abuse and Neglect, Personal Support Services, Nutrition and Hydration, and Sufficient Staffing.

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S. O. 2007, c.8,s.6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:
1 The Resident's plan of care including the Master Profile change, the minutes of Resident Care Conference and the email from ADOC all dated July 14, 2010 indicates he/she requires assistance with meals. The assistance was not provided on August 31 as verified by the Critical Incident Report and the home's internal investigation.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.75(1). Every licensee of a long term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutritional care and dietary service for the home.

Findings:
1. There was no nutritional manager at the time of the inspector's visit as verified by the inspector's visit to the kitchen office.
2 . The RD, ADOC and RN were interviewed and they also verified that there was no nutritional manager..

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Additional Required Actions:]

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by having a manager in place who shall lead the nutritional care and dietary service for the home.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Delores MacDonald Nov 26, 2010
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).