Ontario

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
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, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
August 11, 2010	2010_138_943_10Aug130419 2010_148_943_10Aug115056	Complaint O-000683

Licensee/Titulaire
Taminagi Inc., 05 Loiselle Street, CP Box 2132, Embrun, ON, K0A 1W1 Fax 613-835-2982

Long-Term Care Home/Foyer de soins de longue durée
Sarsfield Colonial Home, 2861 Colonial Road, PO Box 130, Sarsfield On, K0A3E0

Name of Inspector(s)/Nom de l'inspecteur(s)
Paula MacDonald (ID #138) and Amanda Nixon (ID #148)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to provision of care.

During the course of the inspection, the inspectors spoke with: members of the management team including the administrator, dietitian, RAI - coordinator/registered nurse, as well as dietary aides and cooks, and personal care workers.

During the course of the inspection, the inspectors: observed a meal service, reviewed the nursing policy and procedure manual, and reviewed a resident's health care record.

The following Inspection Protocols were used in part or in whole during this inspection:
Personal Support Services Inspection Protocol.

☐ There are no findings of Non-Compliance as a result of this inspection.

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

1 WN

NON- COMPLIANCE / (Non-respectés)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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*

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. Resident was ordered a therapeutic diet by Barbara Khouzam, the home's Registered Dietitian, to manage bowel continence to assist with wound care . Resident received incorrect beverage item at the breakfast meal on August 11, 2010 and resident drank a portion of that beverage. LTCH Inspector #148 intervened and correct beverage was provided.
2. Resident was ordered interventions by Barbara Khouzam, Registered Dietitian, for wound care management. Resident failed to receive intervention at breakfast on August 11, 2010.
3. Resident's family member reported an incident that related to resident's risk of choking. The incident was documented in the health care record. Direction was given to staff and the plan of care was updated with new interventions. Chantal Crispin, Adminstrator, confirmed resident did not receive new interventions after the iincident had been reported.
4. Residents plan of care directed personal care staff to keep him/her clean and dry. Chantal Crispin, Administrator confirmed a personal care staff member did not follow resident's plan of care for bowel continence care.

Inspector ID #:	138 and 148

Signature of Licensee or Representative of Licensee / Signature du Titulaire du représentant désigné Helen Haugen RN	**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.** Paula MacDonald
Title: **Date:** Sept. 27/10	**Date of Report:** (if different from date(s) of inspection). Sept 27, 2010