Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_683126_0019	022090-17	Complaint

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET CORNWALL ON K6J 5V8

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

SANDFIELD PLACE
220 EMMA STREET CORNWALL ON K6J 5V8

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 16, 17, 20, 21, 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and a resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 was admitted to the home with several diagnoses.

On a specific date in 2017, it was documented in the progress notes that while two Personal Support Workers (PSW) attempted to transfer resident #001 back to bed after breakfast, PSWs leaned him/her forward to put the lift sheet under the resident and that he/she slipped to the floor. PSWs lowered resident #001 slowly from the wheelchair (w/c) to the floor. No injury was noted. Physician and Substitute Decision Maker (SDM) were notified.

On November 20, 2017, the Director of Care indicated to Inspector #126 that the Registered Nursing staff are expected to file a Risk Management Form after a fall and that the information is supposed to auto populate in the progress notes. The Risk Management Form (RMF) includes the incident description, the nursing and client description and the description of action taken. A RMF was completed 8 days after the incident of that specific date in 2017. The DOC could not recall exactly which PSWs were involved in the incident and had no written documentation on the follow up investigation conducted of that specific incident in 2017.

On November 21, 2017, telephone interview with Registered Nurse #100, indicated to Inspector #126 that there was one incident when the resident slipped from the w/c to the floor. RN #100 indicated that the incident occurred on a specific date in 2017 and that she documented the incident in the progress notes. RN #100 indicated that two PSWs were in the room at the time of the incident and that post fall, a discussion was held with both of the PSWs at that time. RN #100 indicated that resident #001 did not sustain any injury from sliding out of the w/c. RN #100 indicated that she was reminded by Management to fill out a RMF eight days later.

On November 21, 2017, telephone interview with PSW #101, indicated to Inspector #126 that, she and PSW #102 were going to transfer resident #001 from the w/c to the bed. PSW #101 indicated that the resident was sitting at the edge of the w/c and started to fall down on the floor. PSW # 101 indicated that they guided him/her to the floor. PSW #101 indicated that she had transferred resident #001 on several occasions and that was the only time that this happened.

On November 21, 2017, telephone interview with PSW #102, indicated to Inspector #126 that she and PSW #101 were going to transfer resident #001 from the w/c to the bed. She indicated that resident #001 was sitting at the edge of the w/c and they were putting the sling behind him/her. PSW #102 indicated that resident #001 started to slide down of the w/c. PSW #012 indicated that they lowered him/her to the floor in a very slow motion and that resident #001 did not sustain any injury.

The licensee does not have a post fall assessment using a clinically appropriate instrument designed for falls. [s. 49. (2)]

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 when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for fall, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

On a specific date in 2016, it was documented in the progress notes that resident #001's Substitute Decision Maker (SDM), requested that a specific medication be put on hold until the SDM spoke to to the Nurse Practitioner to discuss the pros and cons of that medication.

On that specific day in 2016, it was documented in the Medication Administration Report, that the medication was administered and signed for by RN #104.

Inspector #126 could not interview RN #104 as he no longer works in the home.

On that specific date in 2016, the SDM had requested to have the medication put on hold and one dose of the medication was administered that same day. [s. 29.]

Issued on this 29th day of November, 2017

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

Original report signed by the inspector.