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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2019	2019_520622_0023	018108-19, 018273-19	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

HEATH HEFFERNAN (622)

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): September 17, 18, 19, 20, 23, 24, 25, 27, 2019 and September 26, 30, 2019 off-site in the office.

The following logs were completed during this inspection:

Log #018273-19 for a complaint related to alleged neglect of a resident and injury of unknown origin.
Log #018108-19/Critical Incident System report (CIS) #2778-000009-19 for a critical incident related to the same resident and injury of unknown origin.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Coroner, the Physician (Medical Director), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and resident family.

Also during the course of the inspection, the inspector reviewed the complaint intake and applicable Critical Incident System report (CIS), electronic and hard copy health records, communication book records, the licensee's investigation documents, the Coroner's report, hospital documents, the Deputy Chief Paramedic’s statement, the licensee’s policies; #4.1.12 Falls Prevention Program, #4.1.2 Abuse and Neglect Prevention Program, #4.14 Pain Management, and staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and   O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any falls prevention policy, the licensee is required to ensure that the falls prevention policy is complied with.

According to O. Reg. 79/10, s. 48 (1)., every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

Specifically, staff did not comply with the licensee’s policy #4.1.12 - Falls Prevention Program, which stated under post falls management procedure on page 7, that the interdisciplinary team will complete the risk management report and a detailed progress note as part of their Falls Preventions and Management Program.

On September 27, 2019, inspector #622 reviewed the progress notes on Point Click Care which stated that resident #003 had a fall on a specified date while walking to the bathroom. The progress note did not include information such as where and how the resident was found at the time of the fall, if the resident was being assisted at the time of the fall, if the resident was using their assistive device, and did not identify staff.

On September 27, 2019, inspector #622 reviewed the risk management report on Point Click Care related to resident #003’s fall on the specified date. The risk management report stated that resident #003 had a controlled fall to the floor while being ambulated to the bathroom with staff. The document did not identify staff or if the resident was using their assistive device and further stated that there were no witnesses. The factors section of the risk management report stated that the predisposing situation was that resident

#003 was ambulating with assistance.

During an interview with inspector #622 on September 27, 2019, RN #102 stated that the reason that the progress notes dated on the specified date stated that resident #003 fell while going to the bathroom and did not mention staff assistance, while the risk management report for the same fall stated that resident #003 had a controlled fall and was lowered to the floor by staff, was that they must have missed documenting.

During an interview with inspector #622 on September 27, 2019, the Administrator reviewed the progress note and the risk management report on Point Click Care for resident #003's fall on the specified date and stated that the documentation in the progress note and the risk management report should have included names of witnesses, where and how resident #003 was found, whether they were laughing or crying. The Administrator further stated that the risk management report and the progress notes on Point Click Care for resident #003's fall on the specified date were not complete or detailed. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 3rd day of October, 2019

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

Original report signed by the inspector.