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
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Original Public Report

Report Issue Date: October 31, 2023	
Inspection Number: 2023-1269-0003	
Inspection Type: Critical Incident	
Licensee: 458422 Ontario Limited	
Long Term Care Home and City: Sandfield Place, Cornwall	
Lead Inspector Severn Brown (740785)	**Inspector Digital Signature** Severn Brown Digitally signed by Severn Brown Date: 2023.10.31 11:53:00 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23, 25, 26, 2023

The following intake(s) were inspected:

- Intake: #00089692 -CI: 2778-000008-23 - Fall of resident resulting in injury and change in condition.
- Intake: #00089906 -CI: 2778-000009-23 - Fall of resident resulting in injury and change in condition.
- Intake: #00094952 -CI: 2778-000010-23 - Fall of resident resulting in change in condition.
- Intake: #00098949 -CI: 2778-000012-23 - Fall of resident resulting in injury and change in condition.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee failed to ensure that a skin assessment was performed on a resident when they returned from hospital.

Summary and Rationale
A resident returned from hospital after being evaluated for a possible injury after a fall. The resident's documentation in their electronic chart was reviewed by the inspector after their return from hospital, and no documentation of a skin assessment post hospitalization was found. A Registered Nurse (RN) stated they received the resident upon their return from hospital but did not perform a skin assessment. Another RN stated that residents are to receive a skin assessment upon return from hospital and that it is the responsibility of the RN to perform the skin assessment.

By not ensuring a skin assessment was performed on a resident after they returned from hospital, the resident was put at risk of having unassessed skin impairment.

Sources:
A resident's electronic chart;
Interviews with two RNs.

[740785]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that a medication cart containing drugs and drug related supplies was locked.

Summary and Rationale

A medication cart next to the nursing station containing topical prescription medications and drug related supplies was observed to be unlocked on multiple days during the course of the inspection. The Director of Care (DOC) and the Infection Prevention and Control (IPAC) Lead both stated that the cart needs to be locked when not attended.

By not ensuring that a medication cart was locked when not in use, residents were put at risk of accessing drugs and drug related supplies that could cause harm if used inappropriately.

Sources:
Observations of a medication cart;
Interviews with the DOC and IPAC Lead.

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