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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2014	2014_289550_0003	O-000926-13	Critical Incident System

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered staff (RN) and two Personal Support Workers (PSWs)

During the course of the inspection, the inspector(s) reviewed CIS log O-000926-13, a specified resident health record and observed residents care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there is an interdisciplinary falls and management program to reduce the incidence of falls and the risk of injury to residents as follows:

As reported on critical incident, Resident #1 fell on a specific date in September 2013 and sustained a fracture to a specific body part. Resident died four days later.

A review of Resident #1's health record indicated no post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Immediate and long term care actions are identified and documented on Resident #1's incident report.

The Director of Care stated to the inspector there is no interdisciplinary falls prevention and management program developed and implemented in the home and they do not have a clinically appropriate post fall assessment instrument. All incidents of residents falling are kept in a binder in the DOC office. The DOC does the follow ups on all falls and when it is noticed a resident falls often, she will discuss with a nurse and identify interventions. These interventions are documented in the resident's respective chart in the progress notes. [s. 48. (1) 1.]

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 in ensuring that an interdisciplinary falls and management program is developed and implemented in the home, to be implemented voluntarily.

Issued on this 27th day of January, 2014

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