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 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
Jan 22, 2019	2019_617148_0001	027412-18, 027414-18	Follow up

Licensee/Titulaire de permis

Taminagi Inc.
5 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

AMANDA NIXON (148), LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 8 and 9, 2019

This inspection was to follow up on two Compliance Orders (CO) issued as a result of the Resident Quality Inspection (RQI) (#2018_619550_0009).
CO #001 (log 027412-18), related to the resident-staff communication response system, specifically at the toilet, tub and shower locations; and CO #002 (log 027414-18) related to the use of bed rails in the home, specifically bed evaluation and resident assessment.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Registered Nurses (RN), Maintenance Staff Member, Personal Support Workers (PSW) and residents.

In addition, the Inspector observed resident care areas including resident bedrooms, bed systems and resident tub/shower rooms. Health care records, relevant assessment forms and policies were also reviewed.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2018_619550_0009	148
O.Reg 79/10 s. 17. (1)	CO #001	2018_619550_0009	148

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident is reassessed and the plan of care reviewed and revised when the care set out in the plan is no longer necessary.

A Compliance Order related to the use of bed rails was issued to the licensee on October 1, 2018, during the RQI (#2018_619550_0009). In response to the CO, the Administrator and DOC #110 proceeded to remove all bed rails from use. A progress note dated June 20, 2018, written by the home's DOC #110, described that an administrative decision was made to remove all assisting rails on all three resident care floors and that residents would be reassessed for transfer and safety needs.

Seven of the residents identified to have bed rails in use during the RQI between May 29 and June 7, 2018, were observed during this inspection. Resident #001, #002, #003, #004, #005, #006 and #007 were observed in bed to have no bed rails in use at this time.

The plans of care in place between May 29 and June 7, 2018, indicated that each of the identified seven residents required bed rails for some purpose, including safety, comfort, repositioning, bed mobility and/or transfers.

During an interview with the RAI Coordinator, it was reported that after the discontinuation of the bed rails the plans of care were updated; however, the revision of each plan of care was completed over the next three months in conjunction with the scheduled Minimum Data Set (MDS) assessments. During an interview with DOC #101, it was reported that at the time of the discontinuation of the bed rails, alternative devices such as transfer poles and fall mats were not available for all residents. The DOC noted that it has been over time, since June 20, 2018, that the home has acquired the necessary devices.

The Inspectors reviewed the health care records of the identified residents and found no documented assessment in relation to the discontinuation of bed rails on June 20, 2018. In discussion with the Administrator, DOC #101, RAI Coordinator, Registered Nursing Staff and Physiotherapist, the home was unable to demonstrate that the residents identified were assessed when the care set out in the plan was no longer necessary. (Log 027414-18)) [s. 6. (10) (b)]

Issued on this 22nd day of January, 2019

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

Original report signed by the inspector.