Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 2, 2021	2021_683126_0001	002273-20, 018664-20, 001138-21, 001744-21	Complaint

Licensee/Titulaire de permis

2629693 Ontario Inc.
c/o Sarsfield Colonial Home 2861 Colonial Road, P.O. Box 130 Sarsfield ON K0A 3E0

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

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): February 9 (onsite), 10, 11, 17, 18, 19, 23, 2021

During the course of this inspection the following logs were inspected:
Log #002273-20: Critical Incident (CI) # 0943-000001-20 significant change in condition that required a transfer to hospital
Log #018664-20: CI #0943-000008-20 related to resident to resident abuse
Log #001138-21 & Log #001744-21: complaints related to infection control, resident nutritional care and housekeeping.

During the course of the inspection, the inspector(s) spoke with the President of the Home, the Administrator, the Director of Care (DOC), one Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Manager of the Environmental Services, several family members and several residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 plan of care was effective related to pain management.

Resident #001 health care record reviewed. It was noted that for a specific period of thirteen days in 2020 resident complained about pain.

Resident was administered acetaminophen four times a day and received eight in between doses for pain management as the resident continued to complained of pain during that period. The plan of care was not revised to implement interventions to manage the pain.

An x-ray requisition was completed as urgent on a specific date and the x-ray was done eleven days later. The resident was diagnosed with a fracture.

Resident #001 pain was not managed effectively during that period until the diagnosis of a fracture.

Sources: critical incident # 0943-000001-20, resident #001's health care record and interviews with RN #101 and other staff. [s. 6. (11) (b)]

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 to ensure that when a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that acetaminophen was administered to resident #001 in accordance with the directions for the use specified by the prescriber which indicated a limit a maximun of 3 grams per day.

Resident #001 health care record reviewed. It was noted that for a specific period of thirteen days in 2020 resident complained about pain.

Resident was receiving acetaminophen four times a day and received eight doses as in between doses for managing the pain during that period. Physician prescription was for resident to receive a maximum dose of 3 grams/day. As per Medication Administration Record (MAR), resident #001 received extra doses of acetaminophen on six occasions which exceeded 3 grams/day.

Sources: Resident #001 health care record, two specific months of MAR and interviews with the Director of Care # 100. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately notified of resident to resident abuse.

On a specific date in 2020, resident #002 hit resident #003 which resulted in in an injury. Charge Nurse #101 contacted the afterhours number the next day to report the incident. The Director was not notified immediately.

Sources: residents health care record, Critical incident # 0943-000008-20 and interviews with Charge Nurse #101 and other staff. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was notified of the incident of resident to resident abuse which resulted in an injury.

On a specific date in 2020, resident #002 hit resident #003 which resulted in an injury. The Critical Incident Report was reviewed and interviews were conducted and it was noted that the police force was not notified of the incident.

Sources: Critical Incident Report and interviews with DOC #100 and other staff. [s. 98.]

Issued on this 5th day of March, 2021

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

Original report signed by the inspector.