



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 le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office 347 Preston St, 4th Floor OTTAWA, ON, K1S-3J4 Telephone: (613) 569-5602 Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa 347, rue Preston, 4ième étage OTTAWA, ON, K1S-3J4 Téléphone: (613) 569-5602 Télécopieur: (613) 569-9670

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 4, 9, 2012, 2012_039126_0007, Complaint

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

SARFIELD 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.

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC), one Registered Nurse(RN) and one Registered Practical Nurse(RPN).

During the course of the inspection, the inspector(s) reviewed the resident health care record and reviewed policies on fall prevention monitor(10.12) and fall risk assessment (10:06)

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
 - i. persons who may dispense, prescribe or administer drugs in the home, and
 - ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 130.1 in that steps are taken to ensure the security of the drug supply, including the following: All area where drugs are stored shall be locked at all times , when not in use. On October 4, 2012 around 13:13, the medication cart was noted to be left unlocked when not in use, in the hall way in front of the nursing station on the second floor. Around 13:15 the Registered Nurse was coming back to the nursing station and witnessed the medication cart being unlocked and unattended. The RN indicated that the RPN was in the front sitting room, approximately 3 rooms down the hall way from the medication cart.

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 the medication carts are kept locked at all time when not in use, 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 subsections:

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 :



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
prévues le Loi de 2007 les
foyers de soins de longue

1. The licensee has failed to comply with O. Reg 79/10 s.131 (2) in that the analgesic has not been administered to the resident in accordance with the directions for the use specified by the prescriber.

As per the progress note's of June 8 and June 11, 2012 resident #1 was complaining of back pain and was not administered any analgesic at the time of the complaints.

The Medication Administration Record (MAR) was reviewed for that period and no analgesic was signed for or given. The DOC reviewed the MAR's and progress note's with the Inspector. No documentation was identified that the analgesic as needed prescribed by the physician, was administered to the resident for pain.

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 medications is administered for pain management as prescribe by the physician, to be implemented voluntarily.

Issued on this 9th day of October, 2012

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

A handwritten signature in black ink, appearing to read "K. Harker" or similar, written over a white background within a rectangular box.