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
Feb 18, 2021	2021_520622_0003	001170-21, 001172-21	Complaint

Licensee/Titulaire de permis

458422 Ontario Limited
220 Emma Street Cornwall ON K6J 5V8

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

Sandfield Place
220 Emma Street Cornwall ON K6J 5V8

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

HEATH HEFFERNAN (622)

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 4, 5, 8, 9, 11, 12, 2021

The following intakes were completed during this complaint inspection:
Log # 001170-21 and 001172-21, related to falls prevention and restraints/PASDs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN)s, Restorative care/BSO and Personal Support Workers (PSW)s.

Also during the course of the inspection, the inspector reviewed resident health records, licensee policies specific to: Restraint Policy # 4.1.3 and made observations of resident care and services.

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

During the course of this inspection, Non-Compliances were issued.

- **3 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 has failed to ensure that different approaches were considered in the revision of a resident's falls plan of care when the care in the plan was not effective.

A resident fell on a date in December 2020 and sustained an injury. The plan of care specified that the resident was to use two specific assistive devices for falls prevention.

Documentation on point click care stated that the resident had removed one of their assistive devices when they fell.

The progress notes indicated that the resident had removed both assistive devices multiple times since April 2020.

The Registered Nurse (RN) stated that fall plan of care interventions had not been revised and that different approaches were not considered when the resident was able to remove both assistive devices. This placed the resident at increased risk for falls.

Sources: review of the health records and interview of RN 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 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any assessments completed with respect to a resident under the restraint program were documented.

The licensee's Restraints Policy #4.1.3, stated that an initial restraint assessment was to be completed when applying a restraint or personal assistance service device (PASD).

The physician's orders indicated that an assistive device had been ordered as a PASD for a resident.

A review of the restraint/PASD assessments on point click care indicated that an initial restraint/PASD assessment had not been documented prior to the resident using the assistive device as a PASD.

Sources: resident health records, the licensee's Restraints Policy #4.1.3, interview with an RN and other staff. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident no later than one business day after the occurrence of a fall incident that caused an injury to a resident, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

The Critical Incident System report (CIS) related to the fall incident of the resident was submitted to the Ministry of Long-Term Care on a date in December 2020.

Progress notes stated that the resident returned from the hospital with a significant change in their health condition two days prior to the submission of the CIS report to the Ministry of Long-Term Care.

Sources: Critical Incident System report (CIS), resident health records and interview of the Director of Care. [s. 107. (3) 4.]

Issued on this 19th day of February, 2021

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

Original report signed by the inspector.