



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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 10, 12 ^{10-12 Dr} 2011	2011_041103_0002	Critical Incident

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Director of Care, Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident health care files, reviewed the home policies and observed residents.

The following Inspection Protocols were used in part or in whole during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions

WN – Written Notification
 VPC – Voluntary Plan of Correction
 DR – Director Referral
 CO – Compliance Order
 WAO – Work and Activity Order

Définitions

WN – Avis écrit
 VPC – Plan de redressement volontaire
 DR – Aiguillage au directeur
 CO – Ordre de conformité
 WAO – Ordres : travaux et activités



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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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits sayants :

A Mandatory report was not made in accordance with the legislative requirements.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
 - i. names of all residents involved in the incident,
 - ii. names of any staff members or other persons who were present at or discovered the incident, and
 - iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
 - i. what care was given or action taken as a result of the incident, and by whom,
 - ii. whether a physician or registered nurse in the extended class was contacted,
 - iii. what other authorities were contacted about the incident, if any,
 - iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
 - v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
 - i. the immediate actions that have been taken to prevent recurrence, and
 - ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits sayants :



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1. A Mandatory report submitted by the home did not include the names of all staff members involved in an incident.

Issued on this 13th day of May, 2011

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

Murphy