



**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 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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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 20, 2018	2018_380593_0001	000863-18	Complaint

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### **Licensee/Titulaire de permis**

458422 Ontario Limited  
220 Emma Street CORNWALL ON K6J 5V8

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

Sandfield Place  
220 Emma Street CORNWALL ON K6J 5V8

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

GILLIAN CHAMBERLIN (593)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): March 14 - 15, 2018.**

**The following intakes were inspected during this inspection: 000863-18.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Dietary Staff, Personal Support Workers (PSW) and residents.**

**The inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment and reviewed resident health care records.**

**The following Inspection Protocols were used during this inspection:  
Nutrition and Hydration  
Reporting and Complaints**

**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)**



**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

Legendé

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.



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**WN #1: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the accidental and unexpected death of resident #001 was reported to the Director immediately.

A Critical Incident (CI) was submitted to the Director related to an incident resulting in the unexpected death of resident #001.

The CI was submitted to the Director nine days after the incident actually occurred.

During an interview with Inspector #593, March 15, 2018, DOC #100 indicated that they were aware of the immediate reporting requirements for unexpected deaths however could not recall why the CI was not submitted immediately. [s. 107. (1) 2.]

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**Issued on this 29th day of March, 2018**

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



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**Original report signed by the inspector.**