Ontario

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_594624_0025	021864-17, 024341-17	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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

BAIYE OROCK (624)

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): October 24, 25, 26, and 27, 2017

The following logs were inspected concurrently:
Log #021864-17 related to a complaint about falls prevention, pain management and plan of care,
Log #024341-17 related to the death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Coroner, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a family member.

A review was also completed of the deceased resident's health records, the licensee's investigation notes and relevant policies and procedures related to falls prevention, pain management, and progress notes documentation.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Personal Support Services

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.

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):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

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

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The Licensee failed to immediately notify the Director of the unexpected death of resident #001.

Related to log #024341-17,

A Critical Incident Report (CIR) was submitted to the Director on a specified day. According to the CIR, on a specified date and time, resident #001, while seated in the dining room, vomited and was diaphoretic. According to the CIR, the resident was assessed, noted to be responsive, afebrile and his/her vital signs noted to be within normal limits. Approximately five hours later, the resident began vomiting again, was re-assessed by a registered staff and transferred to hospital where he/she passed away on same day. The Director was not notified of the sudden death of this resident until two days later.

In separate interviews conducted by Inspector #624 with RPN #101, RN #107, the Director of Care (DOC), and the Administrator about the licensee's expectation on reporting incidents of unexpected or sudden deaths of resident to the Director, they all indicated that the licensee's expectation is that any sudden or unexpected death in the home should be reported immediately to the Director.

Issued on this 8th day of November, 2017

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

Original report signed by the inspector.