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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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, 2020	2020_810654_0002	023977-19, 024342-19, 000812-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor BRAMPTON ON L6T 4B9

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

Sheridan Villa
2460 Truscott Drive MISSISSAUGA ON L5J 3Z8

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

SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 04, 06, 07, 10, 11, and 12, 2020.

Log #0023977-19, #024342-19, and #000812-20, were related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Supervisor of Care (SOC), Medical Director (MD), Registered Staff RN/ RPN, Personal Support Worker (PSW), and residents.

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews of residents' clinical records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #002 was protected from abuse.

A Critical Incident System (CIS) report was reported to the Ministry of Long-Term Care (MLTC), related to an incident of staff to resident alleged abuse that occurred on an identified date. A review of the CIS indicated that resident #002 reported that PSW #107 abused them on the above identified date.

In accordance with the definition identified in section 2(1) of the Regulation 79/1 “physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain to a resident.

Record review of resident #002's Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessment indicated mild to moderate cognitive impairment.

Record review of the resident’s progress notes indicated that on three identified dates the resident reported to three identified registered staff that PSW #107 abused them on the above identified date during an identified care. Upon assessment, no injuries were identified. The resident also indicated that the PSW was rude and that they did not want to receive care from them any longer. Police were notified by the home.

In separate interviews with SOC #101 and #102, both SOC's indicated that they had interviewed the resident separately on two identified dates after the above mentioned incident. The resident reported that PSW #107 held their identified body parts during the above identified care and caused pain.

During an interview with resident #002, they indicated that they could recall an incident with PSW #107 that occurred on the above identified date. The PSW pressed hard on the resident’s above identified body parts and caused pain. The resident further indicated that they were afraid of the PSW and did not want to see them again.

Interview with PSW #107 indicated that they provided the above identified care to the resident on the above identified date. The resident was exhibiting identified responsive behaviours as they wanted to go to bed early. During the first attempt to provide care, the PSW was alone with the resident when they had provided care. The resident was upset. During the second attempt, the PSW transferred the resident with RPN #108 using an identified transfer device. They had held the resident’s above identified body parts during the transfer but denied pressing down on them. The resident was screaming during the transfer as they were exhibiting responsive behaviours.

Interview with RPN #108 indicated that they had transferred the resident on the above identified date with PSW #107. During the transfer PSW #107 was standing and holding the resident from an identified side. The RPN further indicated that they can't recall if the PSW had held the resident's above identified body parts during the transfer.

Interview with PSW #110 indicated that they had worked with the resident approximately two to three days after the above identified incident. The resident reported to them that they had pain around the above identified body part which was caused by PSW #107.

Record review of the home's investigation notes indicated that PSW #107 received a one day suspension related to the above mentioned incident. The PSW received education on an identified date regarding the residents' bill of rights.

Interview with the home's DOC indicated that according to the home's investigation the resident provided a consistent statement. PSW #107 was moved to work on another floor. The DOC, SOC #101, and SOC #102 acknowledged that based on the above mentioned scenario the resident reported pain when PSW #107 held their above identified body parts in an identified manner, which constituted physical abuse of resident #002 from PSW #107.

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 to protect residents from physical abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001 received fingernail care, including the cutting of fingernails.

A CIS report was submitted to the MLTC regarding an alleged abuse from staff to resident #001.

During two separate resident observations by an inspector on an identified date, along with RPN #104 and PSW #105, it indicated that resident #001's fingernails were long and unclean. Upon touching the resident's fingernails, they were sharp. The RPN and PSW confirmed the same.

Record review of the resident's plan of care indicated that the resident exhibited identified responsive behaviours towards the staff during care. Interventions involved staff to ensure that the resident's fingernails were clean and remained short to prevent injury.

Interview with PSW #105 indicated that the resident exhibited the above identified responsive behaviours and it was difficult for the staff to provide them fingernail care. The PSW further indicated that the resident's family member provided them with nail care approximately two weeks ago when they visited the resident.

Interview with PSW #106 indicated that registered staff were responsible for cutting the resident's fingernails due to their identified medical diagnosis. Interview with RPN #104 indicated that PSWs were responsible to provide fingernail care to the resident during their bath days. The RPN further indicated that the resident had another identified medical diagnosis and was on identified precautions. The resident's fingernails should have been clean and trimmed short to prevent the risk of infection to others.

Interview with the DOC indicated that PSWs should have collaborated with the registered staff due to the resident's above identified responsive behaviours, and the above identified medical diagnosis to ensure that the resident had received fingernail care. The DOC further indicated that the resident should have received fingernail care, including the cutting of fingernails on their bath days.

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 each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

Issued on this 20th day of February, 2020

[redacted]

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

Original report signed by the inspector.