

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Hamilton District**

119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

**Original Public Report**

<b>Report Issue Date:</b> December 4, 2023	
<b>Inspection Number:</b> 2023-1581-0003	
<b>Inspection Type:</b> Critical Incident	
<b>Licensee:</b> The Regional Municipality of Peel	
<b>Long Term Care Home and City:</b> Sheridan Villa, Mississauga	
<b>Lead Inspector</b> Christie Birch (740898)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Tatiana Pyper (733564)	

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): November 27, 28, 29, 2023  
 The inspection occurred offsite on the following date(s): November 27, 2023

The following intake(s) were inspected:

- Intake: #00019652 - CI-M572-000009-23 - Alleged resident to resident abuse.
- Intake: #00088253 - CI-M572-000027-23 - Alleged resident to resident abuse.
- Intake: #00088858 - CI-M572-000029-23 - Fall of resident resulting in injury.
- Intake: #00090882 - CI-M572-000033-23 - Fall of resident resulting in injury.

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Hamilton District**

119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control  
Prevention of Abuse and Neglect  
Responsive Behaviours  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Directives By Minister-Binding on Licensees

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 184 (3)**

Directives by Minister, Binding on licensees

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applied to the long-term care home.

#### Rationale and Summary

Effective August 30, 2022, the Minister's Directive: COVID-19 response measures for long-term care homes to all Long-Term Care Homes (LTCHs) was updated, pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive relates to the safe operation of LTCHs, specifically to reduce the risk of COVID-19.

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Hamilton District**

119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

Per section 1.2 of the Minister's Directive, licensees are required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-term Care Homes in Ontario , or as amended, are followed

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, dated November 7, 2023, stated, as one of the key defences against the transmission of respiratory viruses, homes must ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times.

- Specifically, for staff, students, volunteers and support workers, masks are required to be worn indoors in all resident areas.

During observations of the lobby, entrance area, hallways and other common areas of the first floor, several staff were observed not wearing masks. Residents were also observed spending time in the main floor lobby, entrance area and hallways on the first floor at times throughout the inspection.

During the inspection, a staff member was observed not wearing a mask while conversing in close proximity with a resident in the first floor lobby of the home. This staff member acknowledged that they should have been wearing a mask when in close of proximity to a resident.

Another observation noted a staff member exit a resident home area on the first floor without a mask on. This staff member acknowledged they had entered a resident home area without a mask on to do a small task and that they should have had a mask on.

In review of COVID-19 Outbreak Management Policy LTC8-07.05, last updated: November 14, 2023, it was noted:

-Staff, students, support worker and volunteers are required to wear a mask when in Resident's areas indoors.

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Hamilton District**

119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

-Masks are no longer required in administrative and staff only areas e.g., lunchrooms, offices, etc.

In review of Staff Screening and Testing for COVID, policy LTC1-03.41 last updated: November 14, 2023, it was noted:

-Masking: Effective November 7, 2023, Masks are required to be worn in all Residents areas indoors.

In an interview, the Administrator and the Infection Prevention and Control (IPAC) Lead, confirmed that the lobby, entrance area and hallways of the first floor of the home were accessible and used by residents. They also confirmed that the expectation of the home was that staff were to wear masks in the resident home areas, but they had not mandated staff to wear masks in the main floor lobby, entrance or hallways of the home.

There was risk to residents of transmission of infection related to failure of staff to wear masks in resident areas.

**Sources:** Observations, COVID-19 Outbreak Management Policy LTC8-07.05, Staff Screening and Testing for COVID, policy LTC1-03.41, Interviews with staff. [740898]

## **WRITTEN NOTIFICATION: Responsive Behaviours**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### **Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)**

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,

(a) integrated into the care that is provided to all residents;

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Hamilton District**

119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

The licensee has failed to ensure that the Responsive Behaviour Program was integrated into the care that was provided to a resident.

**Rationale and Summary**

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care indicating that a resident allegedly caused injury to another resident.

Review of Prevention and Management of Responsive Behaviour Program Policy, last reviewed November 2023, noted residents who displayed responsive behaviours that were problematic, or worsening were required to have a practical, effective approach to change and continuous assessment (P.I.E.C.E.S.) to determine causes for an increase in their behavioural and psychological symptoms associated with dementia.

Review of a resident's clinical records noted that a P.I.E.C.E.S. assessment was not completed when they experienced an increase in behavioural and psychological symptoms.

In an interview with the Administrator conducted, they acknowledged that a P.I.E.C.E.S. assessment was not completed for this resident.

There was risk to residents when a P.I.E.C.E.S. assessment was not completed when the resident experienced an increase in behavioural and psychological symptoms.

**Sources:** review of resident's clinical records, review of Prevention and Management of Responsive Behaviour Program Policy, last reviewed November 2023, and interview with staff. [733564]