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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2018	2018_728696_0011	015851-17, 008786-18, 016838-18, 020337-18	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Sandalwood Park
425 Great Lakes Drive BRAMPTON ON L6R 2W8

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

ZINNIA SHARMA (696)

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): November 16, 19, 20, 21, 22, 23, 26, 27, and 28, 2018.

During the course of the inspection, the following Critical Incident intakes were inspected:

Log #015851-17 related to incident with injury.
Log #008786-18 related to fall with injury.
Log #016838-18 related to fall with injury.
Log #020337-18 related to fall with injury.

During the course of the inspection the inspector toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes, observed housekeeping practices and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) RPN, RAI Coordinator, Kinesiologist, Occupational Therapist, Physiotherapist, Director of Nursing Care (DNC), and General Manager.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary.

Resident #008 had a fall which resulted in an injury. The resident was assessed post fall and a new fall prevention intervention was put in place.

On two occasions, the resident was observed and the specified fall prevention intervention was not in place.

During an interview with Personal Support Worker (PSW) #113, they stated that the specific fall prevention intervention was not being used for the resident as it was no longer necessary.

Registered Practical Nurse (RPN) #114 and the Kinesiologist told the Long Term Care Homes (LTCH) Inspector that it was an expectation that resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

The resident's written care plan was reviewed with RPN #114. They acknowledged that the specified fall prevention intervention was no longer necessary for the resident and

their care plan should have been revised to reflect these changes.

The licensee has failed to ensure that the resident's care plan was reviewed and revised when care set out in the plan was no longer necessary. [s. 6. (10) (b)]

2. A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) stating that resident #005 had a fall while they were ambulating without their assistive device.

The clinical records of resident #005 were reviewed and indicated that the resident had two falls while they were ambulating without their assistive device.

After the first fall, RPN #109 determined that reminding the resident to use their assistive device would be an effective strategy to reduce the risk of another fall.

Resident #005's written care plan did not include any fall prevention interventions. There was no other documentation to indicate that the resident's care plan was reviewed and revised after the first fall.

PSW #108 stated that they only had access to the resident's care plan and depended on it to implement fall prevention interventions.

RPN #109 acknowledged that they did not review and revise the resident's plan of care post fall to reflect the new strategy.

The licensee has failed to ensure that resident #005 was reassessed and the plan of care was reviewed and revised when the resident's care needs had changed. [s. 6. (10) (b)]

3. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

The clinical record of resident #008 was reviewed and revealed that they had nine falls over a two month period. After each fall, the resident was re-assessed but there was no documentation to indicate that different approaches were considered in the revision of the plan of care.

The resident's written care plan did not identify any new approaches or fall prevention interventions that were considered and tried during this period.

During an interview with RPN #114 and the Kinesiologist, they stated that it was an expectation that the resident was assessed after each fall and different approaches were considered in the revision of the plan of care.

The Kinesiologist, who was the home's Falls Lead, acknowledged that different approaches were not considered for resident #008 between the specified period, when the fall prevention interventions in place were ineffective.

The licensee has failed to ensure that when resident #008 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care. [s. 6. (11) (b)]

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 the licensee must ensure that:
A. the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective.
B. when a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices, assistive aids, or positioning aids, used for the personal support services program were appropriate for the resident based on the resident's condition.

In 2017, a CI report was submitted to the MOHLTC stating that resident #004 sustained an injury while using their assistive device.

PSW #106 and Registered Nurse (RN) #017 told the LTCH Inspector that they had observed resident #004 slipping off their assistive device several times prior to the incident in 2017.

Resident #004's clinical records were reviewed. On a specific date in 2016, it was documented that the resident went out of the home independently using their assistive device and was found by a staff member to be unsecured. The resident were unable to reposition themselves independently.

After the incident in 2016, resident #004 was assessed by an Occupational Therapist (OT) and recommendations were made to apply certain changes to the resident's assistive device to prevent sliding.

There was no documentation in the resident's clinical records to indicate that changes were implemented to the resident's assistive device prior to the incident in 2017.

RN #102 acknowledged that recommendations from OT were never put in place for resident #004's assistive device. They stated that it should have been implemented as it was appropriate for the resident's condition and was recommended by OT.

The licensee has failed to ensure that assistive device used for resident #004 were appropriate and based on the resident's condition. [s. 30. (1) 2.]

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 the licensee must ensure that where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #004's clinical records indicated that they acquired an area of altered skin integrity in 2017. There was one weekly skin assessment that was not completed as required during a specific month in 2017.

During an interview with RN #102, they stated that after a new skin issue was identified, registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. The LTCH Inspector and the RN reviewed the weekly skin assessment records for the specific month in 2017.

RN #102 acknowledged that the registered staff did not complete a weekly skin assessment for resident #004's altered skin integrity. [s. 50. (2) (b) (iv)]

2. Resident #006 exhibited altered skin integrity that required a dressing.

The LTCH Inspector reviewed the clinical record of resident #006 for a specific period in 2018 and found that the weekly assessment for their altered skin integrity was not completed as required.

During an interview with RN #102 and the Director of Nursing Care (DNC), they both told the LTCH Inspector it was expected that weekly skin assessments were to be conducted on any altered skin integrity until it had healed.

RPN #112 acknowledged that the registered nursing staff failed to complete a weekly skin assessment for resident #006 during the specific time period.

The licensee has failed to ensure that resident #004 and #006, who were exhibiting altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 the licensee must ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determined that an injury to a resident had resulted in a significant change in the resident's health condition or remained unable to determine whether the injury had resulted in a significant change in the resident's health condition, informed the Director of the incident no later than three business days after the occurrence of the incident, and followed with the report required under subsection (4).

On a specific date in 2017, a CI report was submitted to the MOHLTC stating that an incident occurred that caused an injury to resident #004 for which they were taken to the hospital and which led to a significant change in the resident's health condition.

Resident #004's clinical record showed that the incident took place on an earlier date and they were transferred to the hospital immediately post incident.

RN #102 told the LTCH Inspector that this incident resulted in a significant change to resident #004's condition as it impacted their activities of daily living.

DNC stated that they were aware that such incidents needed to be reported no later than three business days after the occurrence of the incident. They acknowledged that this incident was not reported within the three business days. [s. 107. (3.1) (b)]

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 the licensee must ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4), to be implemented voluntarily.

Issued on this 27th day of December, 2018

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

Original report signed by the inspector.