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
May 9, 2019	2019_538144_0023	025999-18, 027223-18, 030183-18, 030690-18	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

CAROLEE MILLINER (144)

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): May 6, 7, and 8, 2019.

The following intakes were inspected within this inspection:
Log 025999-18, CIS 2859-000023-18 related to prevention of abuse and neglect
Log 027223-18, CIS 2859-000024-18 related to behaviors and altercations
Log 030183-18, CIS 2859-000028-18 related to behaviors and altercations
Log 030690-18, CIS 2859-000029-18 related to falls prevention and management
Log 002679-19, CIS 2859-000001-19 related to air temperature.

During the course of the inspection, the inspector(s) spoke with one resident, the General Manager, Director of Care, Director of Environmental Services, the Kineseologist, one Registered Nurse, four Registered Practical Nurses and three Personal Support Workers.

During the course of the inspection, the inspector observed four residents, reviewed six resident clinical records, the home's resident contracted private services policy, manual transfers policy, prevention of abuse and neglect policy, the neighborhood coordinator job description and maintenance equipment repair records and invoices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

Ontario Regulation 79/10, r.5. For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

One CI was reviewed by the inspector and included an injury to the identified resident.

The Director of Care (DOC) said that the involved care giver provided personal care to the resident on the date the injury occurred.

Review of the clinical record for the resident confirmed that the written plan of care and minimum data set (MDS) assessment at the time of the incident, identified the residents' current care needs.

One Registered Practical Nurse (RPN) shared with the inspector, the supervisory responsibilities of resident home area Neighborhood Coordinators and the care that care givers could provide if they had their Personal Support Worker (PSW) certificate.

The Kineseologist shared that a component of their role was to provide training for new personnel related to specific care need techniques for residents, that orientation was provided to specific care givers by the Volunteer Coordinator and that certain care givers did not complete the care needs related to the residents' injury.

The DOC shared that one identified care giver was not provided with orientation to the home, the residents' plan of care and the care need techniques provided by the Kineseologist.

The DOC confirmed that one identified care giver provided care to the resident by themselves and that the care provided resulted in an injury to the resident. [S.19]

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 residents shall be protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 9th day of May, 2019

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

Original report signed by the inspector.