

**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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 23, 2020	2020_821640_0004	018208-19, 021269-19	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

HEATHER PRESTON (640)

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): January 13, 14 and 15, 2020.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, conducted interviews, reviewed clinical records and policy and procedure.

The following Critical Incident (CI) Report was reviewed:

Log #021269-19 related to a fall resulting in a fracture.

The following Follow Up report was reviewed:

Follow up log #018208-19 related to Compliance Order #001 issued September 6, 2019, during inspection #2019_787640_0023 with a Compliance Due Date of November 29, 2019 related to s. 54 (4) of O. Reg. 79/10.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Support Ontario (BSO) Lead, Fall Prevention Lead, Kinesiologist, Associate Director of Nursing Care (ADNC), Director of Nursing Care (DNC) and the General Manager.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

**2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
- (a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
 - (b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
 - (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. The licensee failed to comply with compliance order (CO) #001 issued September 6, 2019, with a compliance due date of November 29, 2019, under inspection #2019_787640_0023 for s. 53 (4) of O. Reg. 79/10.

The licensee was ordered to:

The licensee must comply with O. Reg. 79/10, s. 53 (4).

Specifically, the licensee must:

- 1) Ensure that resident #004 and #006 and any other resident has their responsive behaviour of wandering assessed and interventions put in place to respond to their needs and,
- 2) Ensure that the responses to those interventions are documented.

The licensee failed to ensure that, for resident #006, actions were taken to respond to the needs of the residents including assessments and interventions and that the resident's responses to those interventions were documented.

The LTCH Inspector reviewed the clinical record for resident #006 regarding the compliance order and the requirement to assess the responsive behaviour, implement interventions as a result of that assessment, and document the responses to those interventions.

The LTCH Inspector was not able to locate any documented assessment, interventions implemented, or documentation related to the responses to those interventions.

RPN #105, the BSO Lead, said they had not specifically assessed resident #006 for their specific responsive behaviour. They discussed this resident and others at huddle meetings but those were of a general nature. They said there was no documentation of interventions related to an assessment or their effectiveness.

The resident was observed by the LTCH Inspector to continue to demonstrate the specific responsive behaviour.

The licensee failed to ensure that assessments and interventions were implemented and responses to those interventions were documented for resident #006, to respond to their specific responsive behaviour. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of an outbreak of a reportable disease.

During a Critical Incident (CI) inspection, the Long-Term Care Homes (LTCH) Inspector noted that all four home areas in the home were contained for respiratory outbreak. The LTCH Inspector was unable to locate a submission of a CI Report to the Director.

The Associate Director of Nursing Care (ADNC) and RPN #106 said that symptoms began on an identified date in December 2019, on one home area. Staff began to monitor the residents using their “Infection Surveillance” assessment form in their electronic documentation system.

The DNC said that it was reported to them that several residents, on one home area, had respiratory symptoms. After review, the DNC identified nine residents with two or more symptoms of a respiratory nature. They notified the local Public Health department who advised them what action to take. On an identified date in December 2019, the Public Health representative declared the home in respiratory outbreak.

The DNC said they had been unsuccessful submitting a CI report to the Director and they believed the report was not required to be sent immediately.

The licensee failed to ensure that the Director was immediately notified of the respiratory outbreak. [s. 107. (1) 5.]

Issued on this 28th day of January, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : HEATHER PRESTON (640)

Inspection No. /

No de l'inspection : 2020_821640_0004

Log No. /

No de registre : 018208-19, 021269-19

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jan 23, 2020

Licensee /

Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, KITCHENER, ON,
N2E-4H5

LTC Home /

Foyer de SLD : The Village of Sandalwood Park
425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Zoie Mohammed

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Linked to Existing Order /** 2019_787640_0023, CO #001;
Lien vers ordre existant:**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 53 (4).

Specifically, the licensee must:

- 1) Ensure that resident #006 and any other resident has their responsive behaviour of wandering assessed and interventions put in place to respond to their needs and those are documented and,
- 2) Ensure that the responses to those interventions are documented.

Grounds / Motifs :

1. The licensee failed to comply with compliance order (CO) #001 issued September 6, 2019, with a compliance due date of November 29, 2019, under inspection #2019_787640_0023 for s. 53 (4) of O. Reg. 79/10.

The licensee was ordered to:

The licensee must comply with O. Reg. 79/10, s. 53 (4).

Specifically, the licensee must:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1) Ensure that resident #004 and #006 and any other resident has their responsive behaviour of wandering assessed and interventions put in place to respond to their needs and,

2) Ensure that the responses to those interventions are documented.

The licensee failed to ensure that, for resident #006, actions were taken to respond to the needs of the residents including assessments and interventions and that the resident's responses to those interventions were documented.

The LTCH Inspector reviewed the clinical record for resident #006 regarding the compliance order and the requirement to assess the responsive behaviour, implement interventions as a result of that assessment, and document the responses to those interventions.

The LTCH Inspector was not able to locate any documented assessment, interventions implemented, or documentation related to the responses to those interventions.

RPN #105, the BSO Lead, said they had not specifically assessed resident #006 for their specific responsive behaviour. They discussed this resident and others at huddle meetings but those were of a general nature. They said there was no documentation of interventions related to an assessment or their effectiveness.

The resident was observed by the LTCH Inspector to continue to demonstrate the specific responsive behaviour.

The licensee failed to ensure that assessments and interventions were implemented and responses to those interventions were documented for resident #006, to respond to their specific responsive behaviour.

The severity of this issue was determined to be level 2, minimal harm or minimal risk. The scope of the issue was determined to be level 2, pattern as one of two residents named were involved. The compliance history was determined to be level 4. A compliance order (CO) being re-issued related to the same subsection and three or fewer COs as follows:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

- CO to s. 54 (4) issued September 6, 2019, from inspection
#2019_787640_0023 with a compliance due date of November 29, 2019.

(640)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Feb 28, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of January, 2020

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Heather Preston

Service Area Office /

Bureau régional de services : Central West Service Area Office