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

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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
Aug 10, 2020	2020_826606_0015	003035-20	Complaint

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 15, 16, 17, 20, 21, 22, and 23, 2020.

The following complaint intake was inspected:
Log #003035-20 regarding an allegation of an improper transfer of a resident resulting in a serious injury and decline in their health status.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 36. were identified in the Critical Incident System (CIS) #2020_826606_0014 (log #001121-20 and #010299-20) inspection and will be issued in this Complaint inspection inspection report conducted concurrently during the time of the CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Services (DNS), Neighbourhood Coordinators, Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Duty Care Providers, Substitute Decision Makers (SDM) and residents.

The inspector also toured a resident home area, observed resident staff interaction, reviewed relevant residents' clinical records, Home’s investigations, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) A complaint submitted to the Ministry of Long Term Care (MLTC) alleged resident #001 was transferred improperly by staff and sustained a serious injury and declined in their health status.

Resident #001’s progress notes reported the resident fell when Personal Support Worker (PSW) #104 used a different type of transfer equipment by themselves. Resident #001's plan of care stated they required an identified number of staff using an identified type of transfer equipment for all their transfers.

PSW #104 acknowledged that they used the incorrect number of staff and transfer equipment to transfer resident #001. This was confirmed by Neighbourhood Coordinator #102 and an identified private duty care provider who witnessed the incident.

B) A CI reported resident #002 sustained an injury due to an improper transfer by a staff member.

Resident #002’s plan of care stated the resident required an identified number of staff and an identified transfer equipment to transfer the resident.

PSW #105 said they transferred resident #002 on their own and acknowledged the resident required an identified number of staff using an identified transfer equipment to transfer the resident. This was confirmed by Neighbourhood Coordinator 121.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #001 and #002 to transfer. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 12th day of August, 2020

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

Original report signed by the inspector.