Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

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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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
Mar 22, 2021	2021_773155_0004	022950-20, 002109-21, 002117-21	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

SHARON PERRY (155), APRIL TOLENTINO (218)

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): February 25, 26, March 1, 2, 3 and 4, 2021.

The following intakes were completed during this complaint inspection:
Log 002109-21 and log 002117-21 regarding alleged staff to resident abuse; and
Log 022950-20 follow up to CO #001 from inspection 2020_781729_0020 regarding following the medication reconciliation policy and emergency box policy.

This inspection was done concurrently with critical incident inspection #2021_773155_0005.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care, Medical Director, Neighbourhood Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), environmental staff and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, observed resident transfers, and reviewed clinical health records, relevant home policies and procedures, home's investigation notes, education records, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2020_781729_0020	155

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 failed to ensure that two staff members used safe techniques when transferring a resident.

Two staff members transferred a resident from a chair to their bed using a specialized device. When doing so, the resident suffered an injury because safe techniques were not utilized.

The two PSWs did not use safe techniques when transferring the resident despite having had training.

Sources: The home’s investigative notes; resident x-ray reports, progress notes, doctors orders; and interviews with PSW and other staff. [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 all staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 22nd day of March, 2021

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

Original report signed by the inspector.