Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
609 Kumpf Drive, Suite 105
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Original Public Report

Report Issue Date August 2, 2022
Inspection Number 2022_1344_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
The Village of Sandalwood Park, Brampton

Lead Inspector
Jessica Bertrand (722374)

Additional Inspector(s)
Kim Byberg (729)

Inspector Digital Signature
Jessica Bertrand
Digitally signed by Jessica Bertrand
Date: 2022.08.04 15:17:52 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 11-15, 18-20 and 25, 2022.

The following intake(s) were inspected in this complaint inspection:

- Intake #009871-22 (Complaint) and intake #007890-22 (Complaint) related to allegations of abuse and neglect.

The following intake(s) were inspected in this critical incident inspection:

- Intake #009871-22 (CIS #2859-000022-22) related to food and nutrition;
- Intake #007450-22 (CIS #2859-000017-22) related to falls prevention and management;
- Intake #006783-22 (CIS #2859-000015-22) related to continence care;
- Intake #005693-22 (CIS #2859-000013-22) related to concerns of neglect;
- Intake #001108-22 (CIS #2859-000005-22) related to a burst water pipe.

The following intake(s) were inspected in this follow up inspection:

- Intake #008665-22 (Follow-up) for CO#001 with inspection #2022_876606_0011 regarding s. 50(2), CDD June 3, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

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Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 50 (2)	2022_876606_0011	001	729

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION – HOUSEKEEPING

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 93(2)(b)(iii)

The licensee has failed to ensure that cleaning and disinfection of contact surfaces were followed in accordance with evidenced based practices.

Rationale and Summary

Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, recommended when using disinfectant, there should be systems in place to ensure the efficacy of the disinfectant over time, such as reviewing the expiry date.

At the time of inspection, two bottles of chemicals in a resident home area's housekeeping room dispenser were observed to be expired. Products included Vert2Go Bio and Vert2Go glass cleaner.

Three bottles of product were observed to have been removed from the wall dispenser three days after the expired product was discovered. A housekeeper indicated two products that were removed the day before were used daily to clean resident washroom floors. They stated soap from the dispenser was used with warm water that day since the usual product was removed and no replacement was provided or communicated.

The Assistant Environmental Services Manager (AESM) indicated three other bottles were found in other resident home areas and discarded two days after they became aware. They thought the Vert2Go Bio product was not being used by staff.

By using expired cleaning products in the home there was a potential risk of not effectively cleaning and disinfecting contact surfaces.

Sources:
Housekeeping room observations, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, interviews with housekeepers and the AESM..

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WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102(2)(b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary
According to O. Reg 246/22, s. 102(2)(b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

A) The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4(h), documented that the licensee shall ensure the hand hygiene program includes policies and procedures, as a component of the overall IPAC program as well as supporting residents to perform hand hygiene prior to receiving meals and snacks. Hand hygiene includes access to hand hygiene agents, including 70 to 90 percent alcohol-based hand rub (ABHR).

The home's hand hygiene policy indicated to ensure there was no visible soil on hands and then to apply approximately one inch size amount of ABHR from the dispenser. Hand hygiene was be offered for residents around meal and snack times.

At the time of inspection, during lunch meal service in a dining room, alcohol free aloe hand wipes were provided or used to wipe the hands of four residents before they received their meal. ABHR was not provided following use of wipes. Additionally, during the lunch meal service in another dining room, the same type of wipe was used for two residents' hands prior to providing their meal. ABHR was not used at that time.

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A Personal Support Worker (PSW) indicated wipes were used for residents before and after meals and after toileting. The IPAC lead said the direction was to use wipes if residents' hands were visibly soiled then to use sanitizer after. Hands were to be washed in the sink after toileting.

The home's Public Health Nurse confirmed hand hygiene was recommended to be completed with soap and water or sanitizer prior to meals and after toileting.

Not using 70 to 90 percent alcohol-based hand rub for residents prior to meals had a potential risk of not effectively removing bacteria that could spread infection.

Sources:
Lunch service observations, Ontario agency for health protection and promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Hand Hygiene in all Health Care Settings, 4th edition, April 2014, the home's Hand Hygiene policy, IPAC Standard (April 2022), interviews with PSW's, IPAC lead, and the Public Health Nurse COVID Operations, Outbreak Management for Peel Region.

B) The IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1(f) documented the licensee shall ensure that additional precautions are followed in the IPAC program, with additional PPE requirements that include appropriate selection, application, removal, and disposal.

The home's transmission of micro-organisms – contact precautions policy, revised November 2021, indicated that all team members were to wear gloves on entry into a resident's room or bed space if contact with body fluids was likely.

At the time of inspection, a resident was on droplet contact precautions in a home area that was in a COVID-19 outbreak. Public Health Ontario signage on the door directed staff to wear a gown, mask, protective eyewear, and gloves when entering the room. The resident was observed being fed by a PSW not wearing gloves. Additionally, two other staff members were observed feeding residents on droplet contact precautions without gloves three days before.

The home's Public Health Nurse said that all staff members on the outbreak unit should be following droplet contact precautions when providing direct care to residents. They indicated gloves were required to be worn by staff when feeding residents as they would be exposed to bodily fluids.

Not wearing gloves when feeding residents or interacting with a resident on additional precautions in an outbreak unit had a potential risk of spreading COVID-19 to other residents, staff, and visitors.

Sources:

Observations of resident rooms, IPAC standard (April 2022), Public Health Ontario Interim IPAC recommendations for use of PPE for care of individuals with suspect or confirmed COVID-19, the home's IPAC policies, interviews with a PSW, the IPAC Lead, and Public Health Nurse COVID Operations, Outbreak Management for Peel Region.

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WRITTEN NOTIFICATION – FALL PREVENTION AND MANAGEMENT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 49(1)

The licensee has failed to comply with the strategy to monitor a resident after their fall.

In accordance with O. Reg 79/10 s. 8 (1)(b), the licensee is required to ensure the falls prevention and management program must, at a minimum, provide for strategies to monitor residents, and must be complied with.

Rationale and Summary
Specifically, staff did not comply with home's Head Injury Routine (HIR) policy, last reviewed June 7, 2022, which was captured in the licensee's fall prevention and management program.

On a specified date, registered staff were directed by the physician to further monitor a resident for any other signs of decline after the resident presented with an abnormal lab value.

On the same date, the resident had a fall and a head injury routine monitoring form was initiated. Only four of 11 checks were completed and documentation on four of the checks indicated the resident was sleeping. Documentation on vital signs, pupils, Glasgow coma scale for eye opening, verbal response and best motor response was not completed at these times.

A Registered Practical Nurse (RPN) indicated if a fall was not bad, the resident does not complain of pain, and there was no bruising, then the practice was to not disturb residents when they were sleeping. The Falls Lead indicated the home's process was to complete the HIR when the resident was sleeping.

As a result of incomplete documentation, there was risk that if the resident had sustained a head injury, it would not have been identified and treated.

Sources:
A resident's progress notes and assessments, head injury routine – LTC Policy, revised June 7, 2022, interviews with a RPN, Falls Lead and Director of Nursing Care (DONC).

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WRITTEN NOTIFICATION - REPORTS RE: CRITICAL INCIDENT

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.107(4)(4)(ii)

The licensee has failed to ensure that when a Critical Incident (CI) report was submitted to the MLTC related to an emergency that resulted in an unplanned evacuation, material in writing was included that outlined the long-term actions planned to correct the situation and prevent recurrence.

Rationale and Summary
The home submitted a CI to the MLTC related to an emergency that resulted in an unplanned evacuation of residents from their resident home area.

The CI indicated the long-term actions the home planned to correct the situation and prevent recurrence was pending. The Assistant Environmental Service Manager (AESM) acknowledged they did not update the CI with the outcome of the emergency or the long-term actions that the home put in place to prevent recurrence.

Sources:
CI #2589-000005-22, interview with the AESM.

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WRITTEN NOTIFICATION - PLAN OF CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.6(1)c

The licensee has failed to ensure that when a resident experienced an elevated temperature, the staff had clear direction from the resident's physician to provide a specified medication.

Rationale and Summary
The physician's move in/return to the village orders for a resident directed staff to administer a medication when there was an oral temperature over a specified temperature or for an axilla temperature over a specified temperature.

A Registered Nurse (RN) stated the home only used tympanic and forehead thermometers. The RN and two RPN's indicated three different temperatures that would be considered as a fever.

When a resident had an elevated temperature using a tympanic thermometer, the specified medication was not provided. The physician's directions did not give staff clear direction on when to provide the medication using a tympanic or temporal thermometer.

Sources:
A resident's assessments and electronic Medication Administration Record (eMAR), physician's move in/return to the village orders/directions, and interviews with an RN, RPN's and the DONC.

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