Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: May 11, 2023

Inspection Number: 2023-1344-0002

Inspection Type:
Critical Incident System

Licensee: Schlegel Villages Inc.

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

Lead Inspector	**Inspector Digital Signature**
Romela Villaspir (653)	Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.05.11 12:19:18 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 1, 2, 3, 4, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:
- Intake #00008293 was related to an injury from unknown cause.
- Intake #00015651 was related to falls prevention and management, and improper care.
- Intake #00018920 was related to falls prevention and management.

The following intakes related to falls prevention and management were completed in this CI inspection:
- Intake #00003769
- Intake #00009030
- Intake #00016451
- Intake #00018407
- Intake #00018791

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

Resident Care and Support Services

Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan, as it related to assistance with toileting.

Rationale and Summary

A resident required assistance with toileting.

On one occasion, the required assistance was not provided by the staff, and the resident sustained a fall with injuries.

By not providing the required toileting assistance to the resident as per their plan of care, the resident had a fall and sustained injuries.

Sources: Resident's clinical health records, the home's investigation notes; Interviews with the Personal Support Workers (PSWs), Registered Practical Nurse (RPN), the Resident Assessment Instrument (RAI)-Lead, Falls Prevention and Management Lead, and the Director of Care (DOC). [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee has failed to ensure that the outcome of the care set out in a resident's plan of care was documented, as it related to assistance with toileting.

Rationale and Summary

A resident's care plan directed the staff to ask and assist the resident to use the washroom at specific

time frames.

On two occasions, a PSW documented that this activity did not occur, prior to the scheduled time frames.

The PSW acknowledged that they would sometimes document earlier than the scheduled time of care.

The DOC indicated that the home's expectation was to accurately document the outcome of the care, after care was provided.

Sources: Resident's clinical health records; Interviews with a PSW, RPN, and the DOC. [653]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

A PSW transferred a resident using the incorrect sling, and a mechanical lift on their own.

On the following day, the resident was noted to have an injury.

The Falls Prevention and Management Lead indicated that using a mechanical lift required two staff members. They had acknowledged that in this incident, the PSW did not use safe transferring techniques when they used the incorrect sling and transferred the resident using a mechanical lift without a second staff member, which may have possibly contributed to the resident sustaining an injury.

Sources: Resident's clinical health records, the home's investigation notes; Interviews with a PSW, the RAI-Lead, Neigbourhood Co-ordinator, Falls Prevention and Management Lead, and the DOC. [653]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that a post-fall assessment was conducted when a resident sustained a

fall in the home.

Rationale and Summary

The home's Falls Prevention & Management Program policy defined "fall" as a sudden, uncontrolled, unintentional downward displacement of the body to the ground or other object. If a resident is lowered to the floor with the assistance of team members, it should be recorded as a "fall".

On one occasion, a resident was walking to their bed when they stumbled, and a RPN held on to the resident and safely landed them down on the floor.

The RPN indicated at that time, the resident did not receive a post-fall assessment as the RPN did not consider the incident as a fall.

The Falls Prevention and Management Lead indicated that as per the home's policy, if the intent was not to go onto the floor, even if the resident was lowered by the staff, it was considered a fall, and a post-fall assessment should have been conducted by the registered staff.

By not conducting a post-fall assessment, there was a risk that other potential injuries were not identified and addressed.

Sources: Resident's progress notes, assessments, the home's Falls Prevention & Management Program [LTC] Policy Tab 06-02; Interviews with the PSWs, RPN, Falls Prevention and Management Lead, and the DOC. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that training on falls prevention and management was provided to a PSW.

Rationale and Summary

One of the PSWs involved in NC #001 did not receive training on falls prevention and management as part of their orientation.

By not providing training on falls prevention and management to the PSW who was a direct care staff, there was a potential risk that the PSW may not have integrated falls prevention approaches, strategies,

and interventions when they provided care to the residents.

Sources: PSW's training records; Interviews with the Falls Prevention and Management Lead, and the DOC. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that a RPN received annual training on falls prevention and management.

Rationale and Summary

The RPN referenced in NC #004 did not complete the annual training on falls prevention and management in 2022.

By not receiving the annual training on falls prevention and management, there was a potential risk that the RPN may not complete proper post-fall assessments, nor integrate falls prevention approaches, strategies, and interventions when providing care to the residents.

Sources: RPN's training records; Interviews with the RPN, the Falls Prevention and Management Lead, and the DOC. [653]