Ontario

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

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

Central West District
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Original Public Report

Report Issue Date: August 1, 2023	
Inspection Number: 2023-1344-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Sandalwood Park, Brampton	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 13-14, 18-21, 24-25, 2023.

The following intakes were inspected in this Complaint inspection:

- Intake #00088592 was related to falls prevention and management, continence care, and plan of care.
- Intake #00090258 was related to medication management, skin and wound prevention and management, plan of care, and an allegation of neglect.

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake #00090170 was related to an allegation of neglect.

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

Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (5)

The licensee has failed to ensure that the person designated by a resident's Substitute Decision-Maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint related to a resident's care in the home. One of the concerns was related to the doctor not calling the resident's family member as per their request, and not being provided an opportunity to discuss their concerns about the resident's care.

The resident's family member had concerns about a medication and a change in the resident's condition, and had asked the registered staff to have the doctor call them. A note was left on the doctor's book indicating that the resident's family member wanted to talk to the doctor on their next scheduled rounds.

On the day of the scheduled rounds, the doctor was on-site at the home, but did not complete their scheduled rounds in the resident's home area due to a respiratory outbreak. The doctor was not notified that the resident's family member requested to speak with them and therefore, the family member did not receive a call from the doctor as per their request. As a result, the resident's family member was not provided an opportunity to fully participate in the development and implementation of the resident's plan of care, as it related to their concerns with the resident's medication and change in condition.

Sources: Resident's clinical health records; Interviews with the resident's family member, 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 (7)

The licensee has failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan, as it related to a falls prevention intervention.

Rationale and Summary

The MLTC received a complaint related to a resident sustaining multiple falls in the home.

The resident was at risk for falls and required the implementation of a device as a falls prevention intervention. The Personal Support Workers (PSWs) on each shift were required to confirm and document whether the device was applied and working.

On one occasion, the resident had an unwitnessed fall in their bedroom. At the time of the incident, the device was not working.

By not ensuring that the device was applied and working, the staff were not alerted when the resident stood up from the bed.

Sources: Resident's clinical health records; Interviews with the SDM, the DOC, and other staff. [653]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (a)

The licensee failed to comply with the organized program of nursing services for the home, when a resident's medical device was not managed as per the home's policy.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents, and must be complied with.

The home's policy related to the use of a medical device captured under the program of nursing services, required the monitoring, measurement, and documentation of the resident's output by the PSWs. The policy provided directions to registered staff for further assessments and interventions, as it related to the use of the medical device.

The MLTC received a complaint related to an allegation of neglect of a resident resulting in multiple readmissions to the hospital.

A) On one occasion, the resident returned to the home from the hospital with a medical device in place. The required monitoring, measurement, and documentation of the resident's output while using the medical device, were not completed by the PSWs for eight days, following the resident's readmission to the home from the hospital.

B) Further review of the resident's clinical health records showed documentation from 27 different shifts wherein the PSWs did not document the resident's output while using the medical device, at the end of their shift as per the home's policy.

By not ensuring that the PSWs monitored, measured, and documented the resident's output at the end of their shift while the resident was using the medical device, there was a risk that the PSWs were unable to identify issues in a timely manner, and a risk that the registered staff were unable to conduct an appropriate assessment and initiate the necessary intervention in a timely manner as it related to the use of the medical device.

Sources: Resident's clinical health records, the home's policy; Interviews with the RPN, the DOC, and other staff. [653]

WRITTEN NOTIFICATION: CARE CONFERENCE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

The licensee has failed to ensure that a care conference of the interdisciplinary team providing care to two residents, were held within six weeks following the residents' admission, to discuss the plan of care and any other matters of importance to the residents and their SDMs, if any.

Rationale and Summary

Care conferences of the interdisciplinary team that were providing care to two residents, were not held within six weeks following the residents' admissions to the home.

By not holding the care conferences within six weeks following the admission of the two residents, their SDMs were not provided an opportunity to discuss any other matters of importance to the residents and

their SDMs, with the entire interdisciplinary team.

Sources: Residents' clinical health records; Interviews with a Neigbourhood Co-ordinator (NC), and the DOC. [653]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

The licensee has failed to ensure that an assessment instrument under the falls prevention and management program, was completed as required.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that the falls prevention and management program is complied with.

According to the home's Fall Prevention & Management Program policy under Post-Fall Management, when a fall is discovered, the Registered Nursing Team Members are to initiate the Head Injury Routine (HIR) assessment instrument for all unwitnessed falls and witnessed falls that have resulted in a possible head injury unless otherwise indicated in the plan of care. The HIR comprised of checking the resident's vital signs, pain, assessment of pupil reaction, eye opening, verbal and motor responses, at specified times.

A resident had cognitive impairment and was at risk for falls.

The resident had three different falls requiring the initiation of a HIR.

The HIRs that were initiated post fall were not completed as scheduled.

By not completing the HIR as scheduled, there was a risk that the registered staff would not be able to identify a change in the resident's neurological status after the falls.

Sources: Resident's clinical health records, Fall Prevention & Management Program policy revised on June 7, 2022; Interviews with the RNs, and the DOC. [653]

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WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident had a medical directive for the administration of two medications as needed (PRN) for a medical condition.

On three occasions, there were indications for the use of the resident's two PRN medications, however, the registered staff did not administer them as prescribed.

By not administering the PRN medications as prescribed by the physician in the medical directives, there was a risk that the resident's medical condition was not managed effectively.

Sources: Resident's clinical health records; Interviews with the DOC, and other staff. [653]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

A resident had a physician's order for a PRN medication.

On one occasion, a family member administered double the dose of the PRN medication to the resident.

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This incident was considered as a medication incident as the resident received double the dose of their prescribed PRN medication.

The medication incident was not documented on a medication incident form together with a record of the immediate actions taken to assess and maintain the resident's health.

By not completing a medication incident form, the medication error was not followed through according to the home's and pharmacy's policies and procedures.

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