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: June 11, 2024

Inspection Number: 2024-1344-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: Schlegel Villages Inc.

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

Lead Inspector	**Inspector Digital Signature**
Yami Salam (000688)	Yami Salam Digitally signed by Yami Salam Date: 2024.06.11 11:49:10 -04'00'

Additional Inspector(s)
Amanpreet Kaur Malhi (741128)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8 -10, 14 - 17, 21 – 24, 27, 2024 The inspection occurred offsite on the following date(s): May 13, 2024
The following intake(s) were inspected:

• Intake: #00115187 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rational and Summary:

During an observation, the inspector noted that plan of care for a resident was not followed as specified in their plan.

A staff member acknowledged the resident's plan of care was not followed.

The resident was at risk of harm when their plan of care was not followed.

Sources: Observation of the resident, review of resident's medical records and interview with. [000688]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (2) 3.

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

3. Every designated cooling area, if there are any in the home.

The licensee failed to ensure that the temperature was measured and documented in writing at minimum, in every designated cooling area of the home.

Rationale and Summary

A record review of the air temperatures indicated that the temperatures were not measured and documented every designated cooling areas of the home throughout the year.

Assistant Director of Environmental Services (ADES) said that temperatures were not recorded for all designated cooling areas and were not being conducted throughout the year.

As such there was risk that the temperature in the home may not be maintained at a comfortable level for the residents.

Sources: Air Temperature Record Logs -2023/2024, Heat related illness and management plan and Interview with home's staff [741128]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed by the method of their choice.

Rationale and Summary

A resident did not receive their preferred method of bathing since admission to the home.

Sources: Resident's Clinical Records, Interview with Resident and with the home's staff. [741128]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, revised September 2023, section 9.1 (d), documented the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: d) proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal and disposal.

A staff member was observed to disinfect a specific PPE and place it with other clean PPE supplies. The unit was on outbreak at the time of the observation.

The home's policy stated that the specific PPE should not be shared as they could not be adequately cleaned.

Placing the specific PPE back in the PPE caddy, could have resulted in other PPE becoming contaminated.

Sources: Observations, Policy Subject: Disinfecting of goggles, face shields and glasses, policy #06-22, last reviewed 09/14/2020, and interview with home's staff. [741128]

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that their medication management policies were implemented in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

Rational and summary:
On a specific day, several residents on a neighborhood received their medications, about two hours late.

The Director of Nursing (DON) stated that registered staff were expected to administer medication within a grace period of one hour before or after the scheduled time.

The home's Administration of Medication Policy stated staff were to administer medications on time. The policy did not include information about a grace period for administering medications.

Resident's were at risk of potential health complications when the staff did not implement the medication management policy.

Sources: Observation, Review of Medication Admin Audit Report, Review of the home's Medication Administration Policy, Review of MediSystem Policy and Procedures, Interview with Director of Care and other staff. [000688]

WRITTEN NOTIFICATION: Chief Medical Officer of Health (CMOH) and Medical Officer of Health (MOH)

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
Chief Medical Officer of Health (CMOH) and Medical Officer of Health (MOH)

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Chief Medical Officer of Health, specified to implement universal masking in confirmed outbreak areas, for respiratory outbreak.

Rationale and Summary
An observation, at a unit with a confirmed respiratory outbreak, indicated that not all staff were wearing a mask.

The IPAC Lead stated that staff were expected to wear masks on outbreak neighborhoods.

Failure to implement universal masking in the outbreak areas, for respiratory outbreak placed residents at risk of exposure and prolonged outbreak.

Sources: Observation, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Ministry of Health, April 2024), Masking Policy #08-12, Last reviewed: 03/05/2024 and Interviews with the home's staff [741128]