Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2013	2013_189120_0074	H-000698-13	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES 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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 22, 2013

During the course of the inspection, the inspector(s) spoke with executive director, unit co-ordinator, registered staff, kinesiologist, personal support workers (PSW) and a resident.

During the course of the inspection, the inspector(s) reviewed the home's policies and procedures on lifts, transfers, fall prevention and management, reviewed a resident's health record, the home's education program on falls, lifts and transfers and staff attendance records for training.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee did not ensure that an identified resident was properly cared for in a manner consistent with their needs.

An identified resident sustained a fracture in 2013 but was not assessed and sent to hospital until one day later. The identified resident was interviewed during the inspection and was able to provide details about the incident leading up to their injury. The resident, who required a wheelchair for mobility, reported that a personal support worker (PSW) wheeled them into a tub room located on their floor on a specified date in 2013. The resident described that they were assisted by a PSW into a standing position and told to hold onto the edge of the bathtub while the PSW moved about in the room. The resident reported that after an unknown period of time they felt like collapsing and that they yelled at the PSW that they couldn't stand and would fall. The resident stated that they tried to reach out towards the PSW with their hands before collapsing. The PSW responded by assisting the resident back into their wheelchair and wheeled them out into the lounge area. The PSW did not report the incident to the registered nurse as per their "Fall Prevention & Management" policy so that an assessment for injuries could be completed. Later that same evening, as the resident was being assisted to bed, they pointed to their injured area which was observed to be slightly red by a PSW. The registered nurse reported looking at the resident's injured area but no further action was taken. A PSW identified the following morning that the resident's injured area was bruised and swollen at which time they were assessed and sent to hospital. [s. 3(1)4]

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 that residents are properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The care set out in the resident's plan was not provided to the resident as specified in their plan.

An identified resident was transferred out of their wheelchair into a standing position by one staff member instead of two. The resident's plan of care clearly sets out that the resident cannot bear any weight and requires two persons during all transfers. As a result, the resident, who was asked to stand and hold onto the edge of a bathtub while the worker completed another task, collapsed and sustained a fracture. [s. 6(7)]

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 that the care set out in the resident's plan be provided to the resident as specified in their plan, to be implemented voluntarily.

Issued on this 18th day of November, 2013

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

B. Susnik