Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 8, 2014	2014_210169_0022	H-001372-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

Long-Term Care Home/Foyer de soins de longue durée

SHERIDAN VILLA
2460 TRUSCOTT DRIVE MISSISSAUGA ON L5J 3Z8

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

YVONNE WALTON (169), ASHA SEHGAL (159), LAURA BROWN-HUESKEN (503), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 15, 16, 17, 20, 24, 27, 2014

During this inspection, the following inspections were also completed. H-00560-14, H-001068-14, H-000115-14 and H-001180-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Supervisors of Care, Supervisor-Activation and Volunteer Services, Supervisor of Dietary services, Registered Dietitian, Social Worker, nursing staff, dietary staff, housekeeping staff, Residents and families

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 51. (2)	CO #001	2014_300560_0012	169

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when Resident #101 had a fall, a post-fall assessment was completed using a clinically appropriate assessment instrument that is specifically designed for falls. Resident #101 fell and was sent to the hospital and sustained a fracture. Documentation in the clinical progress notes did not indicate a post-fall assessment was completed to rule out any injury from the fall. The nursing supervisor of care confirmed the lack of a post-fall assessment. [s. 49. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 :

1. Resident #013's plan of care contained conflicting and incomplete care directions related to interventions to manage the risk of falls and injury from falling. The resident was identified as a high risk for falling with a history of falls. A nursing care co-ordinator and clinical documentation confirmed that the electronic "Kardex" used by Personal Support (PSW) to direct the care to be provided to the resident did not contain directions identified in the progress notes or the care plan. The resident's bed was to be placed in the lowest position, a bed and chair alarm where to be used and floor mats where to be in place. The care plan directed that two half rails were to be elevated when in bed, while the kardex indicated that staff were to elevate two full bed rails when the resident was in bed. The resident fell which resulted in the resident sustaining a fracture which significantly affected the resident's health status and functional ability. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Review of progress notes written by the home's RD, revealed that resident #13 had experienced a significant change in health which resulted in poor consumption of meals and weight loss. The resident's family informed that RD the resident had been consuming a specific food item. The family requested the home provide the resident the food item, to be provided daily at lunch as this was a preference of the resident. The RD agreed to this intervention. Progress notes revealed that the RD consulted with the Supervisor, Dietary Services, and the request was unable to be accommodated. Interview with staff and record review revealed that the home did not provide the resident the item at lunch as requested. It was further confirmed that the care set out in the plan of care was not based on the resident's preference for the item at lunch. [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Resident #18 is unable to communicate preferences at meal time. Interview with nursing staff revealed that if a resident is unable to indicate preferences the resident's care plan and diet tool in the servery would be used to determine preferences. Review of the written plan of care and the diet tool in the servery revealed that the resident did not have dietary preferences noted. Interview with nursing staff revealed that they did not have

knowledge of these preferences. The Supervisor, Dietary Services confirmed that the staff did not collaborate in the development of the plan of care related to food preferences for the resident. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #101 as specified in the plan. Resident #101 demonstrated resistive behaviour. The staff were attempting to get the resident up and they demonstrated resistive behviour. The plan of care directed staff to allow for flexibility in activities of daily living routines to accommodate resident's mood and also to try different staff to complete the task. The staff did not try using different staff or re-approach the resident at a later time resulting in the resident falling and sustaining an injury requiring hospitalization. This was confirmed by the clinical documentation and the supervisor of care. [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 that ensures s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. And also ensures that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. And also ensures that the staff and others involved in the different aspects of care of the resident collaborate with each other, (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. And also ensures that the care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that staff complied with the “Nurse Call Bell Pager Procedure” included in the organized program of nursing and personal support services, in relation to the following: [8(1) b]
Staff did not comply with the directions in the “Nurse Call Bell Pager Procedure” provided by the home at the time of this inspection, when Personal Support Workers (PSW) did not carry the pages that alert them when a resident has activated the resident-staff communication and response system. The procedure directed that staff on all shifts were to pick up the pager that corresponds to their resident assignment at the beginning of each shift, test the pager to ensure that it was working and return the pager at the end of the shift.

-Staff were noted to not be carrying the pager that alerted them that that a call had been activated. The resident-staff communication and response system station in the washroom of this room was activated. Staff responsible for providing care to residents in this room confirmed that they were not carrying the pager and when the pager was obtained it was confirmed that the pager was not working and did not register a call from the washroom station in this room. The washroom response system station was activated and staff who were assigned to provide care to residents in this room confirmed they were not carrying the pager. When the pager was obtained it was confirmed that the pager was not working to alert staff that a call had been activated.

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 that ensures Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that food production system provides for standardized recipes for all menus.

The plan of care for resident #302 directs staff to provide puree texture meal for the resident. In October, 2014, the puree texture entrée for the resident was mixed together and gravy was added to the create a smooth, consistency. The dietary aide indicated that no directions were provided related to what fluid was to be added to ensure a smooth consistency or how much fluid should have been added. Interview with the Supervisor, Dietary Services confirmed that standardized recipes were not available for the, puree texture being provided to the resident. [s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system provides for preparation of all menu items according to the planned menu.

The lunch meal preparation was observed in October, 2014. During the preparation of the puree meadow vegetables and the preparation of the puree broccoli a dietary aide was observed to add an unmeasured quantity of margarine and water to the robot coupe. Margarine and water were not listed as ingredients on the standardized recipes for either of the menu items. During the preparation of the puree baked pork chop a dietary aide was observed to add thickener and an unmeasured amount of gravy to the robot coupe. Thickener was not listed on the standardized recipe and the standardized recipe listed a specific amount of brown gravy to be used in preparation of the product. Interview with the Supervisor, Dietary Services confirmed that the identified puree items had not been prepared according to the standardized recipe as part of the planned menu. [s. 72. (2) (d)]

3. The licensee did not ensure that all food and fluids in the production system are prepared, stored and served using methods to: (a) preserve taste, nutritive value, appearance and food quality. [O.Reg.79/10, s .72(3) (a)

On October 15, 2014 the food items served to resident at noon meal did not preserve the quality. The consistency of the pureed food items i.e. pureed turkey, vegetables, fish, peas and mashed potatoes was too runny. The appearance of the pureed food was glossy and sticky. The runny pureed food diluted with excessive liquid and thickener, not only resulting in reduced nutritive contents, altered flavour, appearance but also compromised food quality. [s. 72. (3) (a)]

4. The licensee failed to ensure that the staff comply with a cleaning schedule for the food production, servery and dishwashing areas.

Interviews with dietary staff revealed that cleaning schedules had previously been used for the home's kitchen and dishwashing area, however, were no longer being used. Staff indicated that they cleaned items they dirtied and were unsure who was responsible for cleaning common areas such as storage rooms and fridges. A review of documentation in the kitchen found that there was no cleaning schedule for the month of October, 2014. Interview with the Supervisor, Dietary Services on October 27, 2014, confirmed that the October cleaning schedule could not be located and that staff were not complying with the schedule. [s. 72. (7) (c)]

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 that ensures the food production system must , at a minimum, provide for, (c) standardized recipes and production sheets for all menus (d) preparation of all menu items according to the planned menu. That also ensures ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality. And also ensures that ensure that the home has and that the staff of the home comply with, (c) a cleaning schedule for the food production, servery and dishwashing areas, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council, in relation to the following: [73(1) 2] Resident Council was not provided with an opportunity to review meal times. Resident Council leadership and the minutes of the Resident's Council meeting of February 6, 2014 indicated that the residents were informed that staggered dining would be implemented on second floor on February 24, 2014. Resident's Council confirmed they were not provided an opportunity to participate in a review of these changes either prior to the implementation of the changes or subsequent to the changes. Resident's expressed concern about the staggered meal service in the April 3, 2014 and June 5, 2014 minutes as well as expressed ongoing concerns about the negative effect the staggered meals service has on the quality of the dining experience to the inspector at the time of this inspection. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is both safe and palatable to the residents.

The plan of care for resident #303 indicates that the resident requires total feeding assistance. On October 28, 2014, the resident was observed to have milk and water

sitting on dining table for 37 minutes before assistance was provided to the resident. Prior to assisting the resident with the beverages the inspector inquired about the temperature of the milk. The PSW and dietary aide took the temperature of the milk and reported it to be 63.6 degrees Fahrenheit. The PSW returned the milk to the resident and assisted the resident to consume it. The home's policy, Food Temperatures- Point of Service LTC 04-05.14.14, effective August 12, 2013, indicates cold items are to be served at 40 degrees Fahrenheit or lower and directs staff to place items in a freezer to achieve this temperature range as a corrective action when cold items do not meet this temperature range. Interview with the Supervisor, Dietary Services confirmed that the milk was not served at an acceptable temperature which would be safe and palatable for the resident and corrective action should have been taken when the milk's was noted to be at an unacceptable temperature. [s. 73. (1) 6.]

3. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The plan of care for resident #301 indicates that the resident requires total feeding assistance. In October, 2014, the resident was observed to be provided an entrée at 5:31 p.m. The resident did not consume the meal for 19 minutes. At 5:50 p.m. an identified RN removed the resident's plate to the servery to be reheated and once reheated, provided feeding assistance to the resident. Interview with the registered nurse (RN) revealed that the plate was reheated as it had sat too long and was cold. Interview with the Supervisor, Dietary Services confirmed that the resident required total feeding assistance and should not been provided to the resident until someone was available to provide the assistance required by the resident. [s. 73. (2) (b)]

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 that ensures that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents’ Council. Also the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. Also b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents’ linens are changed at least once a week and more often as needed,
(ii) residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure the process to report and locate resident's lost clothing was implemented in the home, in relation to the following: [89(1) (a) (iv)]
Resident #010 reported to nursing staff that the resident's slippers and socks were missing, resident #017 reported to the Facility Services Manager that two tops were missing and resident #019 reported to nursing staff that a pink sweater was missing. The process developed to report and locate residents' lost clothing and personal items was not implemented in the home. Resident #010, resident #017 and resident #019 confirmed that they have had no follow-up related to their reports of missing clothing and the articles identified had not been returned.
The home provided the policy "Lost and Found Clothing" identified as #LTC6-05.03 and dated January 7, 2011 as well as the document that is required to be completed "Missing Property Investigation" form, last revised on July 25, 2005. When interviewed during the course of this inspection, the acting Facility Services Manager was unfamiliar with the process and where documentation that would indicate the process was being implemented in the home would be located, staff in the laundry department were unaware of the location of any of the Missing Property Investigation forms that the policy indicated were to be maintained in a file by the Laundry Department. Registered and unregulated nursing staff confirmed they had not completed any Missing Property Investigation forms that would indicate that missing items were reported by residents and an investigative process had been initiated in an attempt to locate the missing items. [s. 89. (1) (a) (iv)]

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 that ensures As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, (i) residents' linens are changed at least once a week and more often as needed, (ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and (iv) there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not ensure Residents' Council received a written response within 10 days of receiving Residents' Council advice related to concerns or recommendations, in relation to the following: [57(2)]
The Resident Council liaison and Resident Council minutes confirmed that responses were not provided to Council within 10 days in relation to the following concerns:
-Resident Council minutes of January 16, 2014 indicated that the resident's requested there be more entertainment on the weekends, because when the activation staff are off it was too quiet as well as concerns about the high hair salon prices. Responses to these issues were not provided within 10 day.
-Resident Council minutes of March 6, 2014 indicated the residents would like the "Pub" hours extended by one half an hour. A response to this issue was not provided within 10 days.
-Resident Council minutes of April 3, 2014 indicated the residents expressed concerns that residents were being rushed at meals due to the new dining service hours, there were no clean plates available during meals and that water and milk were being place on the table prior to the residents entering the dining room. Responses to these issues were not provided within 10 days.
-Resident Council minutes of June 5, 2014 indicated concerns that a toilet on the fourth floor had been leaking for six months, the lock was not working on the second floor terrace door and the windows at the front of the home were dirty. Responses to these issues were not provided within 10 days. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents’ Council in acting on the results of the Satisfaction Survey, in relation to the following: [85(3)]
Resident Council leadership and the March 6, 2014 minutes of council meetings confirmed that although the Administrator held meetings to inform staff of the results of the Resident Satisfaction Survey, council was not provided with the results of the survey or an opportunity to provide advice about acting on the results. At the time of this inspection the staff person who serves as the Residents’ Council liaison was unable to provide verification that the results of the survey had been provided to the council. [s. 85. (3)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169), ASHA SEHGAL (159), LAURA BROWN-HUESKEN (503), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2014_210169_0022
Log No. / Registre no:	H-001372-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 8, 2014
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	SHERIDAN VILLA 2460 TRUSCOTT DRIVE, MISSISSAUGA, ON, L5J-3Z8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Griffin

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall prepare and submit and implement a plan that ensures that when any resident falls, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
To be included in the plan is an education strategy to ensure all staff are trained on how to complete a post fall assessment, according to the home policy.
To be included in the plan is a process that ensures ongoing compliance with this requirement.

The plan is to be prepared and submitted to Long Term Care Homes Inspector Yvonne Walton at yvonne.walton@ontario.ca by December 15, 2014

Grounds / Motifs :

1. The licensee has failed to ensure that when Resident #101 had a fall , a post-fall assessment was completed using a clinically appropriate assessment instrument that is specifically designed for falls. Resident #101 fell and was sent to the hospital with a fracture. Documentation in the clinical progress notes did not indicate a post-fall assessment was completed to rule out any injury from the fall. During care , the resident indicated severe pain and was transferred to the hospital where they were diagnosed with a fracture . The nursing supervisor of care confirmed the lack of a post-fall assessment. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of December, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : YVONNE WALTON

Service Area Office / Bureau régional de services : Hamilton Service Area Office