Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 5, 2011	2011_072120_0023	Critical Incident

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator regarding two separate critical incidents.(H-001700-11 and H-001611-11)

During the course of the inspection, the inspector(s) inspected the door access control systems, reviewed relevant resident care documents, the home's investigative notes, the home's policies and procedures regarding lifts and transfers and staff education attendance records related to lifts and transfers.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. [LTCHA 2007, c.8, s.6.(7)] An identified resident was not transferred as specified in her plan of care. In 2011, a witness reported to the home's management staff that they saw a personal service worker transfer the resident alone, without any assistance, potentially jeopardizing their safety. The resident's plan of care specifies clearly that they are to be transferred by 2 individuals. The resident has a sign in their bedroom closet indicating the requirement for a 2 person transfer. The resident's plan of care also identifies the resident as being at high risk of falls. Staff caring for the resident have easy access to the resident's plan of care. The management staff conducted an assessment of the incident and took follow-up action where required.
2. [LTCHA 2007, c.8, s.6.(10)(c)] The plan of care for an identified resident was not effective with respect to their exit seeking behaviour. The resident attempted to leave the building/home area 4 times in the span of one week in 2011. The plan requires staff to divert and re-orient the resident when they attempt to leave and to re-enforce reasons for their placement in the home. On a particular day in 2011, the resident eloped from the building without staff knowledge and was then returned unharmed within several hours. After the elopement, the plan of care was reviewed and revised for the resident's exit seeking behaviour to include increased supervision, a wanderguard bracelet and medication changes.

Issued on this 9 th day of December, 2011

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

B. Smith