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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 11, 2024	
Inspection Number: 2024-1581-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Regional Municipality of Peel	
Long Term Care Home and City: Sheridan Villa, Mississauga	
Lead Inspector Daria Trzos (561)	**Inspector Digital Signature** Daria Trzos Digitally signed by Daria Trzos Date: 2024.03.12 14:41:12 -04'00'
Additional Inspector(s) Parminder Ghuman (706988)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, 23, 26, 27, 28, 29, 2024 and March 1, 4, 5, 2024.

The following intake(s) were inspected:

- Intake: #00108741 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary

The licensee has failed to ensure that the plan of care was revised with an intervention related to nutrition.

Rationale and Summary
A resident was observed during meal using an adaptive device which was confirmed by PSW staff. The Minimum Data Set (MDS) quarterly assessment for the resident indicated that the resident required the adaptive device. The care plan and the dietary profile were reviewed and did not include this intervention. The RD confirmed that the care plan was not revised with the intervention and updated the care plan to include the device.

Sources: Observation of lunch meal service; review of resident's plan of care; interview with PSW staff and the RD.
[561]

Date Remedy Implemented: February 28, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

Rational and Summary
During the initial tour of the home with the maintenance staff, it was observed that doors leading to terraces of the home were not locked. At the time of the observation, the doors were unlocked and the terraces could be accessed by any resident. The Administrator stated that these doors were programmed to be locked on evening/night shift and they were just left open as weather got warmer. Maintenance staff and the Administrator indicated that the doors will immediately be locked.

Not having the terraces doors locked posed a safety risk for the residents.

Sources: Observations and interview with maintenance staff and the Administrator. [706988]

Date Remedy Implemented: February 23, 2024

WRITTEN NOTIFICATION: Plan of Care: revision required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary

The licensee has failed to ensure that the plan of care related to nutrition was reviewed and revised when the care needs changed.

Rationale and Summary
A resident's plan of care indicated that they were at high nutritional risk and required assistance with feeding. Resident was observed to have some difficulty while drinking. The PSW assisting the resident indicated that the resident would benefit from an assistive device. There was no assessment of this intervention and it was not included in the plan of care. The RD was interviewed and stated that the staff should have sent a referral so that they could assess the resident and make appropriate plan. The RD completed the assessment and revised the plan of care to include the use of an assistive device for the resident.

Sources: Observations of a meal service; review of resident's plan of care; interview with PSW staff and the RD.
[561]

WRITTEN NOTIFICATION: Menu planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that milk as part of the planned menu was offered and served at lunch.

Rationale and Summary
The lunch menu indicated that one of the fluids served and available was 2% milk. Observation of a lunch meal service identified that none of the residents were

served milk that day. The PSW staff indicated that milk was not being served at lunch time. Both the RD and the Nutrition Supervisor stated that milk was to be served at all meal services including lunch.

When milk was not offered to residents as per the planned menu, residents may not have met their daily requirement for vitamin D and calcium.

Sources: Observation of lunch meal service; review of the planned menu; interview with PSW staff, Nutrition Supervisor and RD.
[561]

WRITTEN NOTIFICATION: Dining service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure that course by course service of meals was provided for residents.

Rationale and Summary
During observation of a meal service, a PSW staff was assisting a resident and both courses were provided at the same time. Another resident was observed eating independently and they were provided with second course before they were finished eating the first course. During another meal service, a resident was provided

both courses at the same time.
The plan of care for the residents did not include the provision of both courses at the same time.
The RD acknowledged that the meals should have been served course by course.

Sources: Observation of lunch meal services; review of the home's policy "Meal Service-Meal Service Expectations" (Nov 7, 2023), plan of care for residents; interview with RD.
[561]

WRITTEN NOTIFICATION: Dining service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (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.

The licensee has failed to ensure that a resident requiring assistance with eating or drinking was served a meal until someone was available to provide the assistance required by that resident.

Rationale and Summary
The resident's plan of care indicated they were at high nutritional risk and required assistance with feeding. During observation of a meal service, the meal was placed on the table in front of the resident at approximately 10 minutes prior to staff being available to assist. The RD acknowledged that no meal shall be served to residents who required assistance with feeding until staff was available to assist.

Sources: Observation of lunch meal service; review of the home's policy "Meal Service-Meal Service Expectations" (Nov 7, 2023), plan of care for the resident; interview with RD.
[561]

WRITTEN NOTIFICATION: Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the system to ensure the accurate acquisition, dispensing, and receipt, of narcotics used in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home and that it is complied with.

Specifically, the registered staff did not comply with the policy "Documentation of Narcotic and Controlled Medication Counts" reviewed last on November 30, 2023.

Rationale and Summary
The pharmacy's policy "Documentation of Narcotic and Controlled Medication

Counts" reviewed last on November 30, 2023, stated that when receiving the Narcotic/Controlled medication, the staff needed to verify the quantity of medication received and document the total number of tablets, capsules or ampoules on hand. When administering they were required to count the number of tablets, capsules, or ampules administered.

Registered staff was observed administering a narcotic to a resident. The registered staff then, accounted for the dose given and wrote the number of doses left in the card instead of the number of tablets. The narcotic card and the individual narcotic count sheet were reviewed and indicated that when the home received the narcotics from the pharmacy, the amount received was written in doses. Afterwards, after each administration the staff were counting the number of doses given and remaining instead of the number of tablets. The Director of Care (DOC) confirmed that the process in the home was to count each individual tablet and not the dose.

Failing to count doses and not individual tablets may have increased the risk for inaccurate acquisition, dispensing, storage and administration of narcotics.

Sources: Observations; review of the policy "Documentation of Narcotic and Controlled Medication Counts" (November 30, 2023), resident's eMAR, narcotic card, individual narcotic count sheet; interview with registered staff and the DOC. [561]