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

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Original Public Report

Report Issue Date: December 9, 2024

Inspection Number: 2024-1581-0005

Inspection Type:
Critical Incident
Follow up

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Sheridan Villa, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25-29, 2024, and December 2-3, 2024.

The following intakes were inspected:

- Intake: #00121000, was a follow-up to Ontario Regulation 246/22, s. 11 (1) (b), from inspection #2024-1340-0002, with a compliance due date of September 27, 2024.
- Intake: #00123837, was related to an allegation of staff to resident abuse.
- Intake: #00123869, was related to infection prevention and control.
- Intake: #00126881, was related to an allegation of staff to resident abuse.
- Intake: #00128915, was related to falls prevention and management.
- Intake: #00129770, was related to an allegation of staff to resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1581-0003 related to O. Reg. 246/22, s. 11 (1) (b).

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 their plan.

Rationale and Summary
A review of the resident's clinical records, including Documentation Survey Report indicated that staff were to ensure that call bell checks, positioning, possessions, pain monitoring, and prompting (4Ps) were completed on every shift to help mitigate their falls risk. The report also showed that the identified falls intervention strategies were not carried out on various shifts during an identified month in 2024. This information was acknowledged by a Personal Support Worker (PSW), Registered Nurse (RN), and the home's Falls Lead.

Sources: A resident's plan of care, including Documentation Survey Report, and staff interviews.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 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; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
On an identified date, the resident had a disease diagnosis removed from their diagnosis list as documented by the physician. This diagnosis was resolved from the resident's care plan three years after. The resident's record showed that the last intervention related to the disease diagnosis was documented two years prior to the diagnosis being resolved from the care plan.

More recently, the resident had a significant change of status related to their nutritional needs in two identified months related to the disease. The resident also had multiple hospitalization in two identified months, and their hospital records identified abnormal diagnostic readings related to the disease.

The physician acknowledged that they were not aware of the abnormal diagnostic readings, as this information was not included in the discharge summary from the hospital, and identified there were no treatments prescribed by the hospital related to the disease. However, they stated that if they were aware, they may have ordered interventions.

Furthermore, the physician and the Director of Care (DOC) acknowledged that the removal of the resident's diagnosis from their diagnosis list, may have impacted the home's ability to implement orders and initiate interventions for the disease.

On an identified date, the resident was hospitalized for another health issue, but also showed symptoms of the other disease. Upon discharge, they were prescribed treatment for the disease.

By not reassessing the resident's past medical history of the disease, and diagnostic testing results; interventions and possible re-instatement of the resident's diagnosis were impacted. This may have resulted in the inability of the home to properly manage the resident's health condition.

Sources: Review of a resident's clinical records, the home's Management of Diabetes Program last revised; June 4, 2024, and Documentation - Plan of Care policy LTC1-05.32, CI: M572-000043-24, and interview with the Physician, staff, and DOC.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse

by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary
On an identified date, an incident of physical abuse acted by a staff towards the resident was reported by the home to the Ministry. This incident was witnessed by another staff member who reported the incident to a registered staff, however failed to remove the resident from the presence of the staff that allegedly abused the resident. The DOC acknowledged that the witnessing staff should not have left the resident with the staff who allegedly abused the resident, when they left to report the incident.

They also acknowledged that disciplinary actions were given to the staff who allegedly abused the resident, including termination.

The resident was at risk of harm and injury caused by the actions of the staff involved.

Sources: CI:M572-000029-24, a resident's clinical records, the home's investigation notes and interview with staff and the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the

policy is complied with.

The licensee has failed to comply with the procedure to assess a resident immediately upon becoming aware of an alleged incident of abuse.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee was required to ensure a written policy to promote zero tolerance of abuse and neglect of residents was in place, and the policy must be complied with.

Rationale and Summary
The home's Preventing, Reporting and Elimination of Abuse/Neglect policy stated that a head-to-toe assessment was required immediately upon becoming aware of an alleged incident of abuse against a resident. When the home became aware of an allegation of physical abuse against a resident on an identified date, they did not complete a head-to-toe assessment until several hours later. This was also acknowledged by the home's DOC.

Sources: Home's Preventing, Reporting and Elimination of Abuse/Neglect policy, and interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's altered skin integrity was reassessed weekly.

Rationale and Summary
The resident's clinical records showed that an altered skin integrity was identified on an identified date. An initial skin assessment was completed for the altered skin integrity the day after it was identified, and a final skin assessment was completed three months after, indicating that this area had healed.

A review of the weekly skin assessments for the resident showed that there were multiple missing assessments for the altered skin integrity in a span of four months. This was acknowledged by the DOC who confirmed that the expectations were for a weekly skin assessment to be completed for any skin and wound concerns.

The home's Skin and Wound program stated that residents exhibiting altered skin integrity, including skin breakdown, pressure injuries skin tears or wounds must be assessed at least weekly.

The resident's altered skin integrity may have not been appropriately assessed and treated when the licensee failed to complete their weekly skin assessments.

Sources: Review of a resident's clinical records, Skin and Wound Care Program last reviewed September 6, 2024; and interview with staff and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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 has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Rationale and Summary
A: The IPAC Standard for Long-Term Care Homes, Additional Requirement under Personal Protective Equipment (PPE) 6.1, stated that the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level or risk.

During an observation of a specified Home Area, alongside the IPAC Lead, a resident was observed to be on droplet and contact precautions. Gloves and gowns were not available at point of care where all the other PPE were located.

The IPAC Lead verified that gloves and gowns should be available and accessible at point of care.

There may have been a risk of increased transmission of communicable disease when all the required PPE was not available at point of care.

Sources: Observation; interview with the IPAC Lead.

B: The IPAC Standard for Long-Term Care Homes, Additional Requirement under Training and Education 7.1, stated that the licensee shall communicate relevant IPAC information and requirements and provide education to caregivers and other visitors (including family members), which included but was not limited to: applicable IPAC practices, and proper use of PPE.

During an observation of a specified Home Area, alongside the IPAC Lead, a visitor in a resident's room, who was on droplet and contact precautions, was observed not wearing proper PPE while in the resident's room. The visitor was also observed exiting the resident's room while wearing PPE, then going back into the resident's room with the same PPE on.

The IPAC Lead verified that the visitor should have been informed of proper IPAC practices and use of PPE.

There may have been a risk of increased transmission of communicable disease when a visitor did not receive the relevant IPAC information related to applicable IPAC practices and proper use of PPE.

Sources: Observation; interview with the IPAC Lead.