Ontario

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
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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
Feb 9, 2015	2014_278539_0029	H-001480-14	Resident Quality Inspection

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

VALERIE GOLDRUP (539), DARIA TRZOS (561)

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): December 2, 3, 4, 5, 8, 9, 10, 11, and 12, 2014 and January 27, 2015.

Inspector Laleh Newall (147) also conducted the inspection. The following inspections were completed during this inspection: H-000374-14, H-000485-14, H-000599-14, H-001293-14, H-001646-14, and H-001659-14. Follow-up inspections were completed on previously issued orders from the following inspections: H-000708-13, H-000426-14.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care, Director of Environmental Services, Director of Food Services, Neighbourhood Co-ordinators including the Resident Assessment Instrument (RAI) Coordinator, Kinesiologist, registered staff including Registered Nurses and Registered Practical Nurses, personal support workers (PSW), dietary staff, housekeeping staff, Resident Council President, Family Council President, residents and family members of residents.

The inspectors toured the home, observed the provision of care and services provided on all home areas, and reviewed relevant documents including, but not limited to: health care records, policies and procedures, complaint logs, investigation documents, meeting minutes, and menus.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

5 WN(s)
2 VPC(s)
0 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
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2014_266527_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_205129_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_205129_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #003	2013_205129_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #004	2013_205129_0004	539
O.Reg 79/10 s. 43.	CO #008	2013_205129_0004	539
O.Reg 79/10 s. 53. (4)	CO #009	2013_205129_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #005	2013_205129_0004	539
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #006	2013_205129_0004	539

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. 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).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

A)Resident #003 had a half rail applied on their bed. The registered staff and the Personal Support Worker confirmed that the half rail was applied on the bed while the resident was in bed. The RAI Coordinator indicated that the use of half bed rails were not required to be added to the written plan of care, only full bed rails that were considered restraints were expected to be in the written plan of care. The resident’s health records and the written plan of care were reviewed and the use the bed rail was not included in the resident’s plan of care and did not provide clear direction to staff who applied the bed rail.(561)

B)Resident #005 had two half rails applied on their bed. The registered staff and the Personal Support Worker confirmed that the half rails were applied on the bed while the resident was in bed. The RAI Coordinator indicated that the use of half bed rails were not required to be added to the written plan of care, only full bed rails that were considered restraints were expected to be in the written plan of care. The resident’s written plan of care was reviewed and the use the bed rails was not included in the resident’s plan of care and did not provide clear direction to staff who apply the bed rails.(561)

C)Resident #005 had twelve falls over an identified 2 month period of time. A review of the resident's electronic plan of care indicated that the resident should have hip protectors in place. A Personal Support Worker confirmed that the resident had hip protectors and a bed alarm. On December 10, 2014, review of the paper copy of the personal care profile and care plan did not include the use of the bed alarm or hip protectors. The information was to be kept in a binder at the nursing station to guide the personal support workers who did not have electronic access to the plan of care. It was confirmed with a Personal Support Worker and a member of the registered staff that the paper plan of care did not provide clear direction to staff who apply the bed alarm and hip protectors. [s. 6. (1) (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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure alternatives to the use of a Personal Assistance Services Device (PASD) had been considered and tried where appropriate, but would not be or have not been effective to assist the resident with the routine activity of living.

A) Resident #003 had a quarter rail applied on their bed. Review of the clinical record indicated that there was no assessment completed to determine if the bed rail was being used as a PASD. The home's Kinesiologist confirmed that there was no assessment completed and no alternatives have been considered and tried to assist the resident with the routine activity of living.

B) Resident #005 had two half rails applied on their bed (one on each side). Review of the clinical record indicated that there was no assessment completed to determine if the bed rails were being used as a PASD. The home's Kinesiologist confirmed that there was no assessment completed and no alternatives have been considered and tried to assist the resident with the routine activity of living.

2. The licensee did not ensure that the use of the PASD was approved by any person provided for in the regulations.

Review of clinical records for residents #003 and #005 indicated there were no documented approvals for the use of the bed rails as a PASD. The home's Kinesiologist confirmed that there were no approvals obtained for the use of the PASD.

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

Review of the clinical records indicated that residents #003 and #005 or the substitute decision makers of the residents did not provide consent for the use of bed rails as a PASD. The home's Kinesiologist confirmed there was no consent signed by the residents or the SDM's of the residents for the use of bed rails as PASD. [s. 33. (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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living only occurs if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provides for everything required, 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Fall Prevention & Management [LTC] policy, revised February 2013 stated that "a Post-Fall Analysis will be completed by the Registered Team Member 24 hours after the fall occurred. If a Resident has multiple falls within the 24 hour period, all falls will be captured with one analysis. Otherwise each fall will warrant a separate analysis" . A review of the health records for resident #008 indicated that after a fall on 2 identified dates in 2014, the Post-Fall Analysis was not completed by staff. A registered staff member confirmed that the Post-Fall Analysis was not completed for the two falls and that the fall policy was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy was complied with.

In 2014, resident #007 reported to the staff that they were allegedly physically assaulted by a staff when they requested to have their continence product changed. Review of the progress notes and the home's internal investigation notes indicated that this incident was reported to the Charge Nurse on duty. The resident was assessed by the Charge Nurse and it was documented that a "loonie size bruise" was found on the resident's inner right thigh.

According to the home's Prevention of Abuse in Long Term Care – Tab 04-06 last revised November, 2013 – required all team members to report any suspicions, incidents or allegation of abuse immediately to their supervisor or designate, and if after hours the Charge Nurse will advise the On-Call leadership team member and the Ministry of Health (MOH) and Long Term Care at the Mandatory Reporting Line.

Interview with the Director of Nursing Care(DONC) and review of the internal investigation notes confirmed that this incident was not reported to the leadership team by the Charge Nurse as per the home's policy until the following day. At which time the MOHLTC was notified, an investigation initiated and police contacted.(147) [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that planned menu items were offered and available at each meal and snack.

During the observation of lunch service on December 2, 2014, the weekly menu stated that unsalted soda crackers were to be served. The crackers were not listed on the daily menu and no crackers were observed to be offered to residents.

A main meal item posted for lunch service on December 2, 2014 was hot turkey sandwich with cranberry jelly, and herbed green beans. No cranberry jelly was observed during the service. A dietary staff and the Director of Food Services confirmed that cranberry jelly was not available at the lunch service. [s. 71. (4)]

Issued on this 10th day of February, 2015

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

Original report signed by the inspector.