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
Mar 18, 2015	2014_306510_0017	H-000849-14	Critical Incident System

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

IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 3 and 4, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Director of Recreation Services, Coordinator of Volunteers and Social Services, personal support workers, registered staff, volunteer, president of family council and visitors.

During the course of the inspection, the inspector(s) toured the home areas, observed the provision of care and service delivery and reviewed relevant documents including but not limited to clinical records, policies and education/orientation packages for volunteers.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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 has failed to 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).

The Home's policy titled "Prevention of Abuse in Long Term Care" dated November 2013, stated that all team members were required to report any suspicions, incidents or allegations of neglect and/or abuse immediately to their supervisor or designate immediately for further investigation.
On an identified date, staff #001 was sitting at the nurse's station, looking across to the common area where residents were sitting. Staff #001 alleged they observed a visitor touch resident #001 and informed staff #002 of the incident. Staff #002 alleged they witnessed a similar incident previously, which they had reported to the registered staff.
On an identified date, the allegations were reported to management.
During interview on an identified date, staff #002 stated that, approximately two months ago, they observed the visitor touching resident #001. The staff reported the allegation to the registered staff. The allegation was not reported to management. Staff #002 stated that they were familiar with the homes policy that all suspected abuse must be reported.
On an identified date, interview with the registered staff who had been on duty confirmed the conversation with staff #002. The registered staff reported their awareness that the policy of the home required reporting of all suspicions or allegations of abuse to their supervisor.
The "Prevention of Abuse in Long Term Care" policy of the home was not complied with. [s. 20. (1)]

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 home's policy titled "Prevention of Abuse in Long Term Care" is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 223. Orientation for volunteers

Specifically failed to comply with the following:

s. 223. (1) Every licensee of a long-term care home shall ensure that every volunteer receives the orientation provided for in section 77 of the Act. O. Reg. 79/10, s. 223 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that every volunteer receives the orientation provided for in section 77 of the Act. O. Reg. 79/10. S. 223(1)

The homes document 'Definition of a Volunteers' stated "A volunteer is a (unpaid) person with the time to give in service to others".
A program at the home is run by a volunteer routinely. Staff reported that another person from outside the home attends every program session and assists the volunteer with set up of the program. The Director of Recreation Services (DRS) and Administrator confirmed that they were aware of the frequent attendance of the other person in assisting with the specified program. The Co-ordinator of Volunteers and Social Services (CVSS) reported they had been advised the other person sometimes comes in to help with set up.
The DRS reported that this person had applied to be a volunteer and after discussion, the applicant and CVSS agreed not to pursue the person becoming a volunteer. The CVSS confirmed the person did not complete the volunteer orientation program.
Since that time, the person continued to assist regularly with the specified program – as an unpaid person giving time in service to others. This meets the homes definition of volunteer. This volunteer did not receive the orientation provided for in section 77 of the Act. [s. 223. (1)]

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 all volunteers receive the orientation provided for in section 77 of the Act, to be implemented voluntarily.

Issued on this 19th day of March, 2015

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

Original report signed by the inspector.