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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2017	2017_561583_0017	022482-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages 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

KELLY HAYES (583), NATASHA JONES (591), SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 22, 25, 25, 27 and 28, 2017.

During the course of this inspection, the following additional inspections were conducted:

Critical Incident System (CIS) Inspections: Log #003517-17, related to abuse; log #005071-17, related to falls; log #006042-17, related to injury of unknown cause; log #007345-17, related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care (DONC), Kinesiologist, Neighbourhood Co-ordinators, Director of Recreation, Director of Environmental Services, Maintenance Staff, RAI QI Coordinator, Director of Food Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA) and Residents and Residents` Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that care was provided as specified in the plan of care.

On an identified date in 2017, resident #070 had an unwittnessed fall. The resident sustained an injury. The plan of care, identified the resident was at high risk of falls. At the time of the fall, resident #070 was receiving a specialized personal care intervention for a specified time period during the day to provide support for their responsive behaviours. The intervention was not in place as a falls prevention intervention.

Progress notes documented on the date of unwittnessed fall, showed the specialized personal care intervention was not in place at the time of the incident. In an interview with DONC #002 on September 27, 2017, it was confirmed the personal care intervention was not in place as directed in resident #070's plan care at the time of the fall.

PLEASE NOTE: This area of non-compliance was identified during a critical incident system (CIS) inspection, conducted concurrently during this RQI. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of the resident #021's written plan of care indicated the resident had an area

of altered skin integrity in a specified location. A review of the "Skin assessment - quarterly", on an identified date in 2017, for resident #021 did not identify the area of altered skin integrity.

In interviews, registered staff #181 and PCA #184 shared resident #021 had one area of altered skin integrity but not the type specified in the plan of care or quarterly skin assessment. Registered staff #181 further confirmed the written plan of care was not updated after the resident's altered skin integrity had healed. In an interview, DONC #002 stated registered staff were expected to make updates on the written plan of care that is kept on the unit in the PCA binder and are encouraged to update on the electronic copy as well.

The home failed to ensure that the written plan of care for resident #021 was revised when their resident's care needs changed or care set out in the plan was no longer necessary. (591)

B) Observations of resident #084's room were made on three separate dates on identified dates in September 2017. On all three observations the resident was in bed and there were lingering offensive odors. The resident was observed to be in a shared room with another resident.

A review of the plan of care identified resident #084 had a condition which was contributing to the odors. The continence care plan identified that resident #084 had a medical intervention but did not identify the correct information and it did not identify the current issues with the intervention or what strategies were in place to manage the condition and odors.

In an interview with RN #104 and PCA #223 and #224 in September 2017, it was shared that staff were using new interventions to manage the condition and that the odors in the resident #084's shared room had worsened. It was confirmed by RN #104 that the plan of care was not revised when the intervention changed and it was also not revised to include interventions that were required to manage the condition and odors. (583) [s. 6. (10) (b)]

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 care is provided as in the plan of care and to ensure that the residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the act of this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

On an identified date in 2017, resident #084 had an unwitnessed fall and were located by RN #152 with specified falls prevention interventions in place. A review of the resident's progress noted indicated that the resident's vital signs at the time of the fall were noted to be a departure from the resident's normal values. A progress note entered by RN #152 indicated that the resident refused the application of a needed intervention and did not indicate a required vital sign value. The same progress note entry also indicated that the resident's SDM was informed of the fall, but did not indicate that the home's physician was contacted in relation to the change in the resident's status. A review of the physician

contact log and the progress notes did not indicate that RN #152 contacted the home's physician to notify them of the change in the resident's status.

Interview with RN #159 indicated that when a resident's oxygen saturation is below 90% on room air that the RN must report this change to the physician. On review, the home's physician reviewed the resident's fall data at the home, a total of nine (9) days after the resident fell.

A review of the resident's health record indicated that a Head Injury Routine (HIR) was initiated by RN #152. No values were entered for an identified time periods. At times the resident refused to have their vital signs taken; no entries were made in relation to different approaches used.

Interview with RN #159 indicated that when a resident has an unwitnessed fall, the HIR is initiated neurological vital signs are taken every 30 minutes for 2 hours, then on an hourly basis for another 2 hours, then on a four hour basis for a total of 48 hours. RN #159 indicated that resident #084's HIR was not completed as per the home's policy.
A review of the home's policy titled, "Fall Prevention and Management Program LTC", index # 04-33, indicated that when a resident has fallen, registered staff members are to, "initiate the Head Injury Routine for all unwitnessed falls an witnessed falls that have resulted in a possible head injury unless otherwise indicated in the plan of care", and that registered staff must, "notify the attending physician and substitute decision maker (SDM) of the fall and status of the resident". Under the Long-Term Care Homes Act, 2007, Falls Prevention and Management is a required program, and the licensee is required to ensure that the home's falls prevention policy is complied with.

Interview with DONC #002 confirmed that the resident's HIR was not completed fully and that the resident's neurological vital signs were not monitored in accordance with the home's policy. The DONC #002 also confirmed that the home's physician was not notified in a timely manner in relation to the resident's vital signs and that the home's registered staff did not follow the home's falls prevention policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the act of 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, that the licensee ensures that the plan, policy, protocol, procedure, strategy or system is complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was neglected by the licensee or staff.

On an identified date in 2017, resident #096 was observed by a PCA who expressed concerns to RPN #137 stating the resident had an injury of unknown origin and was displaying signs of pain. An interview with RPN #137 indicated that they assessed the resident in the morning and determined that the resident was in pain due to facial grimacing and vocalization. RPN #137 shared that when they assessed the resident there was a large area of altered skin integrity that was not previously noted, and that the resident was unable to weight bear. In an interview with RPN #137 it was confirmed that this was a significant change in the resident's health status as the resident was previously able to walk independently with a mobility aid. A review of the resident's medication administration two hours after the assessment indicated that the resident was provided a standing order of pain management medication.

A review of the progress notes indicated that RPN #137 contacted the resident's SDM to inform them of the resident's change in status. RPN #137 confirmed that they did not

notify the home's physician of the change in the resident's condition, and confirmed that they provided the SDM with incomplete information as assessments and physician recommendations had not been completed. In an interview with RPN #137 it was confirmed that they failed to provide the SDM with a full and accurate assessment in which to make decisions surrounding resident #096's care. RPN #137 also confirmed that during their shift on the identified date in 2017, two other RPNs and one RN were on-site at the home and that they did not request any assistance from these other registered staff members to assess resident #096. A review of the progress notes and assessments indicated that RPN #137 did not initiate or complete a skin and wound assessment in relation to the resident's altered skin integrity of unknown origin, did not initiate or complete a pain assessment in relation to the resident's pain, and did not initiate or complete a falls assessment, RPN #137 was unable to describe why these assessments were not completed as per the home's expectations.

Interview with RPN #204 indicated that the resident was transferred to hospital the next day, after there had been no improvement in the resident's pain or ability to weight bear. On return from the hospital, the resident's SDM reported to RPN #200 that the resident was diagnosed as having a specified type of injury. A progress note entered by RPN #200 stated that the discharge papers did not indicate that there was an injury, and did not indicate that an attempt was made by registered staff to confirm the presence of an injury, this was confirmed by RPN #200. On review of the progress notes, no further attempt to obtain follow up information in relation to the resident's condition was completed for an additional two days, when the report was requested and received via fax by the home.

A review of the home's policy titled, "Prevention of Abuse and Neglect", index # tab 04-06, stated, "Schlegal villages has a zero tolerance policy with respect to abuse of any kind, including physical, sexual, emotional, verbal financial, and neglect from any person", and further stated, "neglect includes a pattern of inaction that jeopardizes the health and safety of one or more residents".

Interview with DONC #001 confirmed that when a resident has had a suspected fall or an injury of unknown cause that a pain assessment, skin and wound assessment, and falls assessment, must be completed. DONC #001 confirmed that the home's physician should have been contacted and given a report with the assessment data by the registered staff prior to informing the SDM to ensure that an informed decision was made. DONC #001 further confirmed that when a discrepancy between the discharge information and information reported by the SDM was brought to RPN #200's attention,

they should have contacted the hospital for clarification to ensure the resident received the care they required. DONC #001 confirmed that there was a pattern of inaction by the registered staff in relation to the care of resident #096 and confirmed that resident #096 was neglected by registered staff in the home.

PLEASE NOTE: This area of non-compliance was identified during a critical incident system (CIS) inspection, conducted concurrently during this RQI. [s. 19. (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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A review of a document titled "Consent form for use of restraint/PASD" dated February 2017, indicated a specified intervention was to be used for the resident as a personal assistive safety device (PASD) for comfort and positioning. The form was signed by the resident's substitute decision maker (SDM). A review of a document titled "Repositioning Record" for the month of September, 2017 indicated resident #040 had a PASD in place and was repositioned in their by PCA staff every 2 hours.

In interviews, registered staff #240 and PCA #210 indicated the wheel chair intervention was used for resident #040 as a PASD for positioning and comfort.
A review of resident #040's current written plan of care did not identify the use of their PASD.

In an interview, DOC #2 confirmed the PASD used by resident #040 was not included in their written plan of care, but should have been. [s. 33. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is (ii) secure and locked, and (iii) protect the drugs from heat, light, humidity, or other environmental conditions in order to maintain efficacy.

During the initial tour of the home on September 22, 2017, at 0915 hours, Inspector #619 identified a basket containing multiple prescription creams located in the Sanders Unit spa tub room. The following topical medications were identified.

Resident #090 – prescription cream
Resident #121- prescription cream
Resident #015 - prescription cream
Resident #095 - prescription cream
Resident #110 - prescription cream

Interview with PCA #103 indicated that PCA's have received training in relation to the application and storage of topical creams, ointments, and lotions. Interview with RN #129 indicated that prescription creams can be stored in a locked room that resident's do not have access to, such as the spa tub room, which requires a security code for entry. A review of the home's policy titled, "Medication System – Medication Storage", last updated January 17, 2017, stated, "all medication are to be stored in a secured, locked location, accessible only to designated staff members", and, "medications should be protected from heat, light, and humidity as per manufacturer's instructions", and, "store additional medication supply in the designated area in the medication room (i.e. inhalers, eye drops, treatments or injectables)".

Interview with DONC #002 confirmed that storing prescription creams in the tub room is not appropriate as non-designated staff members, including housekeeping and maintenance, have access to this locked area, and that these medications are not protected from heat and humidity when stored in a tub room. [s. 129. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program required under section 86(1) of the Act.

During the initial tour of the home on September 22, 2017, at 0915 hours, the Sanders unit home area was observed to have unlabelled used personal hygiene products in the spa tub room. These items included three used unlabeled disposable razors, one unlabelled and used silver colored hair brush, and one unlabelled and used black hair comb. In the same area it was noted that the spa tub had fecal matter smeared on the tub and hair and other particulates were noted in the tubs basin.

The PCA staff members of the home confirmed that these personal hygiene items should be labeled and that that the common use items in the home should be cleaned and sanitized after every use. Interview with DONC #002 confirmed that staff in the home failed to participate in the homes infection prevention and control practices. [s. 229. (4)]

Issued on this 15th day of November, 2017

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

Original report signed by the inspector.