Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2019	2019_787640_0023	010927-19, 014120-19, 015639-19	Critical Incident System

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

HEATHER PRESTON (640)

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): August 27, 28, 29, September 3, and 4, 2019.

During the course of the inspection the LTCH Inspector toured the home, observed the provision of care, interviewed residents, families and staff and reviewed clinical records, policies and procedures.

The following Critical Incident (CI) Reports were reviewed:
Log #010927-19 related to unknown fracture
Log #014120-19 related to fall with a fracture
Log #015639-19 related to fall with injury

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Neighbourhood Coordinators, Behavioural Support Ontario (BSO) Lead, Resident Assessment Instrument (RAI) Coordinators, Kinesiologist, Assistant Director of Care, Director of Recreation, Director of Nursing Care and the General Manager.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident including interventions.

a) Resident #003 had fallen on 14 occasions. On seven of the 14 occasions, the resident had been wandering. They were assessed to be at moderate risk for falling. They walked independently without the use of an aid.

On an identified date in August 2019 the resident had been wandering and entering other residents' rooms and knocking on doors. The nurse administered sedative medication without effect. An hour later the resident was found lying on their bedroom floor. After the fall the resident was administered another medication without effect. The resident kept walking around and was noted to be unsteady on their feet.

The resident fell on another identified date in August 2019 during the night. They had been put to bed by staff and then abruptly left their bed, fell, hit their head and face.

Other than the pharmacological intervention, there were no other interventions documented as tried to assist the resident with their wandering behaviour.

PSW #101 told the Long-Term Care Homes (LTCH) Inspector the interventions related to wandering was the use of a one-to-one staff member to be with the resident.

The plan of care directed staff, for the focus of wandering, to escort the resident from the

dining room or activity.

The licensee's policy "Personal Expression Program", policy #Tab 04-84 with no date provided, directed staff that all personal expressions have meaning.

RPN #104, the Behavioural Support Ontario (BSO) Lead for the home told the LTCH Inspector that wandering was not a responsive behaviour as it was normal for the resident to wander, the wandering behaviour had not been assessed and specific interventions had not been developed in relation to the wandering behaviour.

b) Resident #004 was assessed to be at high risk for falls. Over a two month period, they had four falls. Two of the four falls were out of the room in the lounge area. They walked independently without the use of an aid. They were assessed to have unsteady gait.

Resident #004 had multiple responsive behaviours including wandering.

RN #100 said the resident would most often wander daily, go into other residents' rooms. They would touch other residents and their specialized equipment while the other resident was using the equipment which put the residents at risk.

RPN #100 told the LTCH Inspector the interventions related to wandering was the use of a one-to-one staff member to be with the resident. Staff would try to use the transfer wheelchair, but the resident would resist or be found wandering on the home area.

The LTCH Inspector reviewed the resident's plan of care, in place at the time, which noted one-to-one staff had been implemented related to the safety of others. The plan of care directed staff, for the focus of wandering, to escort the resident from the dining room or activity, encourage the resident to wander on the home area and to provide assistance to find their room.

c) Resident #006 had 14 falls over a three month period. Their fall risk was assessed as high on multiple assessments. Twelve of 14 falls were during wandering episodes. Three of the 12 falls while wandering, incurred an injury. They were assessed to have unsteady gait.

Resident #004 had multiple responsive behaviours including wandering.

PSW #107 said the resident would most often wander daily and would go into other resident rooms.

They told the LTCH Inspector the interventions related to wandering was to sit them in a recliner chair and recline the chair back, hug them, guide them to calm them down and music.

The LTCH Inspector reviewed the resident's plan of care which directed staff under the focus of wandering, to escort the resident to and from dining room and activities. At times they would wander in and out of other residents' rooms and may touch other belongings. They needed to be monitored and redirected throughout the day. Staff were to provide assistance to the resident in locating their own room.

The licensee failed to ensure that interventions had been implemented for residents #003, #004 and #006 to respond to their responsive behaviour. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care, as set out in the plan of care, was documented.

Resident #002 fell on an identified date in July 2019, and sustained a fracture.

The plan of care in place at the time of the fall, directed staff to apply hip protectors with no specificity as to when, how often and for how long. The hip protectors were implemented shortly after admission as the resident was at moderate risk for falls.

The LTCH Inspector reviewed the clinical record, specifically the PSW documentation, and the application of hip protectors was not included in the tasks the PSWs could document in POC.

The Associate Director of Nursing Care (ADNC) told the LTCH Inspector the home expected that the hip protectors were applied as directed in the plan of care. The home did not require staff to document the application of the hip protectors and did not include them in the required documentation in POC.

The licensee failed to ensure that the application of hip protectors was documented as set out in the plan of care. [s. 6. (9) 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 the licensee must ensure that the provision of care, as set out in the plan of care, is documented, to be implemented voluntarily.

Issued on this 18th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l’inspection :	2019_787640_0023
Log No. / No de registre :	010927-19, 014120-19, 015639-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 6, 2019
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Sandalwood Park 425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Zoie Mohammed

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with O. Reg. 79/10 s. 53 (4).

Specifically, the licensee must:

1) Ensure that resident #004 and #006 and any other resident has their responsive behaviour of wandering assessed and interventions put in place to respond to their needs and,
2) Ensure that the responses to those interventions are documented.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident including interventions.

a) Resident #003 had fallen on 14 occasions. On seven of the 14 occasions, the resident had been wandering. They were assessed to be at moderate risk for falling. They walked independently without the use of an aid.

On an identified date in August 2019 the resident had been wandering and entering other residents' rooms and knocking on doors. The nurse administered sedative medication without effect. An hour later the resident was found lying on their bedroom floor. After the fall the resident was administered another

medication without effect. The resident kept walking around and was noted to be unsteady on their feet.

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The plan of care directed staff, for the focus of wandering, to escort the resident from the dining room or activity.

The licensee's policy "Personal Expression Program", policy #Tab 04-84 with no date provided, directed staff that all personal expressions have meaning.

RPN #104, the Behavioural Support Ontario (BSO) Lead for the home told the LTCH Inspector that wandering was not a responsive behaviour as it was normal for the resident to wander, the wandering behaviour had not been assessed and specific interventions had not been developed in relation to the wandering behaviour.

b) Resident #004 was assessed to be at high risk for falls. Over a two month period, they had four falls. Two of the four falls were out of the room in the lounge area. They walked independently without the use of an aid. They were assessed to have unsteady gait.

Resident #004 had multiple responsive behaviours including wandering.

RN #100 said the resident would most often wander daily, go into other residents' rooms. They would touch other residents and their specialized equipment while the other resident was using the equipment which put the residents at risk.

RPN #100 told the LTCH Inspector the interventions related to wandering was the use of a one-to-one staff member to be with the resident. Staff would try to use the transfer wheelchair, but the resident would resist or be found wandering on the home area.

The LTCH Inspector reviewed the resident's plan of care, in place at the time, which noted one-to-one staff had been implemented related to the safety of others. The plan of care directed staff, for the focus of wandering, to escort the resident from the dining room or activity, encourage the resident to wander on the home area and to provide assistance to find their room.

c) Resident #006 had 14 falls over a three month period. Their fall risk was assessed as high on multiple assessments. Twelve of 14 falls were during wandering episodes. Three of the 12 falls while wandering, incurred an injury. They were assessed to have unsteady gait.

Resident #004 had multiple responsive behaviours including wandering.

PSW #107 said the resident would most often wander daily and would go into other resident rooms.

They told the LTCH Inspector the interventions related to wandering was to sit them in a recliner chair and recline the chair back, hug them, guide them to calm them down and music.

The LTCH Inspector reviewed the resident's plan of care which directed staff under the focus of wandering, to escort the resident to and from dining room and activities. At times they would wander in and out of other residents' rooms and may touch other belongings. They needed to be monitored and redirected throughout the day. Staff were to provide assistance to the resident in locating their own room.

The licensee failed to ensure that interventions had been implemented for residents #003, #004 and #006 to respond to their responsive behaviour.

The severity of this issue was assessed to be level 2, minimal risk of harm. The

scope of the issue was determined to be level 3, widespread. The compliance history was determined to be level 3, previous non-compliance with the same section as follows:

- a VPC was issued during Inspection #2017_561583_0002 on February 27, 2017.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Central West Service Area Office