Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2020	2020_826606_0014	000811-20, 001121-20, 001671-20, 001718-20, 010207-20, 010299-20, 011835-20	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

JANET GROUX (606), NUZHAT UDDIN (532)

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 15, 16, 17, 20, 21, 22, and 23, 2020.

The following Critical Incidents (CI) intakes were inspected:
Log #001121-20 and #010299-20 regarding an improper transfer of a resident causing injury, #001671-20 regarding a resident's fall resulting in a transfer to the hospital, #011835-20 regarding an injury of unknown origin, #010207-20 regarding an allegation of staff to resident abuse causing injury; and #000811-20 regarding late reporting of a Acute Respiratory Illness (ARI) outbreak was previously inspected during the CIS inspection #2020_821640_0004 issued January 23, 2020, and is noted in this report.

The following Follow-up (FU) Order (CO) was inspected:
Log #021269-19, CO #001 from inspection #2020_821640_0004 / 018208-19, regarding regulation 53. (4), with a Compliance Due Date (CDD) of February 28, 2020.

PLEASE NOTE: A Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 36. was identified during the CIS inspection (log #001121-20 and #010299-20) and was issued in the Complaint Inspection Inspection Report #2020_826606_0015 conducted concurrently during the time of the CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Services (DNS), Neighbourhood Coordinators, Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Duty Care Providers, Substitute Decision Makers (SDM) and residents.

The inspectors also toured a resident home area, observed resident staff interaction, reviewed relevant residents' clinical records, Home's investigations, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **1 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
O.Reg 79/10 s. 53. (4)	CO #001	2020_821640_0004	606

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that resident #005 was reassessed and the plan of care 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 Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) related to an allegation of staff to resident abuse. The CI reported resident #005 had an identified injury and alleged the injury was caused during an identified activities of daily living (ADL) on a particular shift.

Personal Support Workers (PSW) #116, #120, and #117 said they work during a particular shift where resident #005 had been identified to require a specific ADL to be provided frequently during the shift due to the resident's health status and identified personal expressions.

PSW #120 said resident #005 was provided a specific ADL during a particular shift once during the shift and was not provided the identified ADL before the resident's bedtime. Registered Nurse (RN) #119 stated that resident #005 was provided an identified ADL but the ADL was discontinued when the resident had a significant change in their condition the previous year. RN #119 said that resident #005 is cognitively aware of of their care needs and because their personal expressions have decreased, the resident could benefit by having an identified ADL to be provided to them.

Resident #005's assessments records did not show evidence that an identified assessment was completed as required when the resident's had a change in condition and when their care needs changed.

The Director of Nursing Services (DNS) said resident #005 should have been reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

The licensee has failed to ensure that resident #005 was reassessed and the plan of care 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. [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 the resident is reassessed and the plan of care 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin tears received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A CI reported resident #002 sustained an identified skin integrity impairment.

Resident #002's progress notes stated PSW #105 reported to Registered Practical Nurse (RPN) #107 that the resident sustained an identified skin integrity impairment during care. Resident #002's clinical records including the resident's progress notes, assessments, and risk management report did not show evidence the resident's skin integrity impairment was assessed and included measurements of the skin integrity impairment describing the length, width, depth, exudate, odour, bleeding, temperature, condition of the skin flap and the peri wound, whether there was inflammation, pain, or any special consideration were required based on the resident’s health condition and other needs that may affect their ability to heal the identified skin integrity impairment.

Neighbourhood Coordinator #121 said that when a resident has been identified with a skin integrity impairment, registered staff are expected to complete an identified Home's skin assessment tool located in Point Click Care (PCC) specifically used to assess a resident who has a skin integrity impairment. They acknowledged RPN #107 did not complete a skin assessment as required. RPN #107 confirmed this.

The licensee has failed to ensure that resident #002's skin integrity impairment was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Issued on this 12th day of August, 2020

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

Original report signed by the inspector.