Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: October 12, 2023	
Inspection Number: 2023-1344-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Sandalwood Park, Brampton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.10.19 09:16:38 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-29, and October 3-5, 2023.

The following intake(s) were inspected:

- Intake #00093111, related to resident care.
- Intake #00093367, related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff involved in a resident's care collaborated with each other in the implementation of the resident's plan of care for falls prevention, to ensure interventions were integrated and consistent.

Rationale and Summary

A resident was at risk for falls.

Upon the resident's admission to the home, an intervention to minimize the risk of injuries from falls was documented in the resident's plan of care.

Approximately two weeks later, this intervention was removed from the resident's plan of care. There was no communication with the home's former Kinesiologist/Falls Lead to re-assess the resident's needs in relation to the intervention.

The home's current Falls Lead and the Resident Assessment Instrument (RAI) Coordinator said that a re-assessment of the resident should have been completed before removing the specific intervention.

Staff not collaborating in the implementation of a resident's falls management plan of care increased the risk that appropriate interventions were not provided and it may have contributed to the resident's injury.

Sources: a resident's clinical records, and interviews with a PSW, an RPN, the home's Falls Lead, the RAI Coordinator, and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care for falls prevention was provided to the resident as specified in the plan.

Rationale and Summary

A resident was at risk for falls. The resident's plan of care for falls prevention documented a specific intervention to be provided to minimize the risk of falls and injuries.

On one occasion, the intervention was not in place as per their plan of care.

The Director of Nursing Care (DNC) said staff should follow the falls prevention interventions as indicated in the resident's plan of care.

By not ensuring that the resident's falls prevention intervention was provided as specified in their plan of care, put the resident at risk for falls and injuries.

Sources: an observation of the resident, a resident's clinical records, and interviews with a PSW, the DNC and other staff. [758]

WRITTEN NOTIFICATION: Complaints Procedure-Licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a written complaint related to a resident's care was immediately reported to the Director.

Rationale and Summary

A written complaint related to a resident's care was received by the DNC.

The DNC said the complaint was not reported to the Director, as required.

By not immediately reporting to the Director the written complaint regarding a resident's care, it may delay the Director's ability to respond to the concerns in a timely manner.

Sources: the home's complaint records, and an interview with the DNC. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that interventions implemented for a resident under the Falls Prevention and Management program, were documented.

Rationale and Summary

A resident was at risk for falls.

The resident's plan of care documented that staff were to check that two specific falls prevention interventions were in place. These interventions were to be documented in the resident's Point of Care (POC) every shift.

There were multiple dates and shifts where the documentation regarding the implementation of these interventions was either missed or not completed as specified in the plan of care.

The DNC said that the interventions for falls prevention should have been documented in the resident's POC as specified in their plan of care.

Gaps in the documentation of the falls prevention interventions made it difficult to evaluate the effectiveness of these interventions.

Sources: a resident's clinical records, and interviews with the DOC. [758]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that interventions to respond to a resident's responsive behaviours were documented.

Rationale and Summary

A resident had a specific responsive behaviour. Staff were to document every shift on POC, the type of behaviour observed, the actions taken to respond to it and the effectiveness of the interventions provided. If the resident did not exhibit behaviours, staff were to document that no behaviour was observed.

In a two-month period, a resident had a change in their responsive behaviours and the interventions in place were not entirely effective. On multiple dates and times during different shifts, when the resident had responsive behaviours and interventions were provided, the documentation on POC was not consistent with the resident's observed behaviours. Additionally, on a specific shift, there was no documentation related to the resident's behaviour.

The DNC and the home's Behavioural Support Ontario (BSO) Nurse said that the resident's behaviours and actions taken should be documented on POC and consistent with the resident's exhibited behaviours.

Gaps in a resident's behaviours documentation increased the risk that the resident's behaviours may not be accurately monitored and analyzed, and appropriate interventions may not be identified and implemented in a timely manner.

Sources: a resident's clinical records and interviews with the home's BSO Lead, the DNC and other staff. [758]

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to the person who made a complaint related to resident's care included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A written complaint related to a resident's care was received by the DNC.

The response to the complainant did not include the Ministry's toll-free number for making complaints about the home and its hours of service and the contact information for the patient ombudsman.

The DNC acknowledged that the response to the complainant did not include the above information as required.

By not providing the complainant with the Ministry's toll free number for making complaints and the contact information for the patient ombudsman, there was a risk that the complainant may not be aware and able to access these resources if needed.

Sources: the home's complaint records and an interview with the DNC. [758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee has failed to ensure that the response provided to the person who made a complaint related to a resident's care included an explanation of what the licensee has done to resolve the complaint.

Rationale and Summary

A written complaint as specified in NC #006 was received by the DNC.

The response to the complainant did not include an explanation of the home's actions to resolve the complaint.

By not providing the complainant with an explanation of what the home had done to solve the complaint, the complainant was not aware of the home's actions and was not satisfied with the response that was provided.

Sources: the home's complaint record, and an interview with the DNC.[758]