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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2014	2014_266527_0003	H-000053-13, H-000167-14	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

KATHLEEN MILLAR (527)

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): January 30, 31, February 5, 10, 11, 12, 13 and 14, 2014.

The inspection conducted was related to two Critical Incidents, Log #H-000053-13 and H-000167-14. The critical incidents were related to the plan of care and suspected abuse.

During the course of the inspection, the inspector(s) spoke with residents, resident family members/power of attorney (POA), Personal Support Workers (PSW), Registered Nursing staff (RPN), the Physiotherapist (PT), the Kinesiologist, the Lead for the Falls Prevention Committee, the Neighbourhood Coordinator, the Behavioural Support Officer (BSO), the Physician, the Director of Nursing (DON), and the General Manager.

During the course of the inspection, the inspector(s) reviewed the residents health records, policies and procedures, training records / educational materials, and conducted observations in common areas of the home and the residents rooms.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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).

Findings/Faits saillants :

1. The Licensee did not ensure that the care set out in the plan of care for Resident #002 and Resident #003 was provided as specified.

(a) Based on the health record, Resident #002 requires two staff to transfer from the bed to the wheelchair and specifies the resident requires the hoyer or sit-to-stand lifting device. When receiving care on two occasions, the resident was manually lifted by one staff member from the bed to the wheelchair. The manual transfers were witnessed. The staff member who provided the resident's care confirmed during the interview the resident was manually lifted from the bed to chair, no lifting devices were used, and two staff to transfer the resident was not used. The staff member confirmed the plan of care for Resident #002 was not followed as specified.

(b) The health record identifies that Resident #003 has difficulties with activities of daily living (ADLs), if awakened too early. The home implemented new interventions based on the most recent quarterly assessment in December 2013 and an evaluation of the interventions deemed them to be effective. The plan of care was revised and specified the new ADL interventions for the resident. The staff member who provided care to resident #003 confirmed during the interview that she did not follow the plan of care as specified. As witnessed and observed, the resident was not able to perform ADLs. [s. 6. (7)]

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 care set out in the plan of care is provided to the residents as specified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee did not ensure that staff used safe transferring techniques and devices for Resident #002 as specified in the plan of care.

(a) The plan of care for Resident #002 states the resident requires assistance with transferring from the bed to the wheelchair. A two person transfer using the hoyer or sit-to-stand lifting device. The staff member providing care on two occasions manually transferred the resident from the bed to the wheelchair by placing two arms under the arms of the resident and pivoting from the bed to the wheelchair. In an interview, staff confirmed the transfer needs of Resident #002. The manual transfer was witnessed and confirmed by the staff member who provided the care on the specified dates. The same staff member also confirmed during the interview that the plan of care was not followed. [s. 36.]

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 staff use safe transferring and position devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's Power of Attorney (POA) was immediately notified upon becoming aware of the alleged, suspected or witnessed abuse or neglect of Resident #002.

(a) The suspected abuse of Resident #002 occurred in January 2014. The home was notified of the suspicions at the beginning of February 2014 and immediately initiated their investigation, however they did not inform the resident's Power of Attorney until seven days later when they should have been informed within twelve hours of becoming aware of the suspected abuse. This was confirmed in the interview with the Director of Nursing (DON) and confirmed in the home's investigation notes. [s. 97. (1) (b)]

Issued on this 27th day of February, 2014

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

Kathleen Millar