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 # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_486653_0006	033942-16, 034196-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 10, 11, 12, and 13, 2017.

During the course of the inspection, the inspector reviewed resident #001's health records, staff schedule, the home's complaint records and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with resident #001's Substitute Decision-Maker (SDM), Personal Support Worker (PSW), Registered Practical Nurses (RPNs), Physiotherapist (PT), and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on an identified date, related to staff not providing the care as specified in resident #001's plan of care for identified care areas, injury of unknown cause and medication changes made that the SDM had not consented to.

During an observation on an identified date, in resident #001's bedroom, it was noted that he/she had an identified transfer logo posted on his/her cabinet.

Review of resident #001's written plan of care completed on an identified date, indicated he/she used an identified lift for transfers.

Interviews with Personal Support Worker (PSW) #100 and Registered Practical Nurse (RPN) #102 stated resident #001 required an identified type of assistance for transfers.

The RPN acknowledged that the resident's written plan of care did not provide clear directions to staff, as it still indicated he/she used an identified lift for transfers.

Interview with the Director of Care (DOC) acknowledged that resident #001's written plan of care did not set out clear directions to staff as it directed staff to use an identified lift for transfers, when the transfer requirement for resident #001 was an identified type of assistance. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The MOHLTC received a complaint on an identified date, related to staff not providing the care as specified in resident #001's plan of care for identified care areas, injury of unknown cause and medication changes made that the SDM had not consented to.

During an observation on an identified date, in resident #001's bedroom, it was noted that he/she had an identified transfer logo posted on his/her cabinet.

Review of the Physiotherapist (PT)'s assessment on an identified date, indicated under the transfer section that resident #001 required an identified type of assistance from wheelchair to standing. Review of an identified assessment signed by RPN #106 on an identified date, indicated the resident required an identified lift with the assistance of two staff members during days, evenings, and nights.

Interviews with PSW #100 and RPN #102 stated resident #001 required an identified assistance for transfers. They further indicated that the resident had been receiving an identified assistance for transfers since an identified date. Interview with RPN #102 acknowledged that staff did not collaborate with each other in the assessment of the resident.

Interview with the DOC acknowledged that collaboration did not occur between the PT and nursing staff. The DOC further indicated that the home's expectation was for staff to collaborate with each other in the assessment of the resident. [s. 6. (4) (a)]

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

The MOHLTC received a complaint on an identified date, related to staff not providing the care as specified in resident #001's plan of care for identified care areas, injury of unknown cause and medication changes made that the SDM had not consented to.

Review of resident #001's written plan of care completed on an identified date, indicated a recommendation for an identified amount of daily fluid restriction as per the physician's order, and that the resident was supposed to be provided three identified amount of beverage of choice including soup and milk at lunch time. It was also indicated that he/she was supposed to be provided with an identified beverage at lunch time.

During an observation on an identified date, from 1142 hrs to 1255 hrs in the dining room of an identified home area, during the lunch meal service, it was noted that resident #001 received identified amounts of identified beverages, and soup which totalled to 475mLs. Resident #001 did not receive an identified beverage.

Interview with RPN #102 acknowledged the inspector's above-mentioned observations. The RPN stated that resident #001 did not receive the an identified beverage because he/she had to return it to the dietary aide, as it was not in an identified consistency. RPN #102 confirmed that the care set out in resident #001's plan of care was not provided to the resident as specified in the plan.

Interview with the DOC stated that the home's expectation was for staff to provide care to the resident as specified in the plan. [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 that
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
-the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
-the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response had been made to the person who made the complaint, indicating: i. what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

The MOHLTC received a complaint on an identified date, related to staff not providing the care as specified in resident #001's plan of care for identified care areas, injury of unknown cause and medication changes made that the SDM had not consented to.

Review of the written complaint letter on an identified date, from resident #001's SDM addressed to the Executive Director (ED) of care, carbon copied to the provincial director of Revera and the MOHLTC, revealed that on an identified date, resident #001's identified body part was reported to be injured. The SDM requested to know what happened. The SDM specified in the written complaint that he/she wanted the incident to be fully investigated.

Review of the DOC's letter of response to resident #001's SDM on an identified date, regarding his/her written complaint letter, the home's Client Services Response (CSR) form and progress notes did not indicate any information that the SDM had been updated regarding the investigation on the above-mentioned incident.

Interview with resident #001's SDM stated he/she had not been notified of the outcome of the investigation regarding his/her complaint related to the above-mentioned incident.

Interview with the DOC stated that the home investigated the reported injury and upon completion of the investigation, the home did not find that an injury had occurred. The DOC failed to show the inspector that he/she had provided a response to the complainant in regards to the result of the investigation on the above-mentioned incident. [s. 101. (1) 3.]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

The MOHLTC received a complaint on an identified date, related to staff not providing the care as specified in resident #001's plan of care for identified care areas, injury of unknown cause and medication changes made that the SDM had not consented to.

Review of the written complaint letter from resident #001's SDM addressed to the ED of care, carbon copied to the provincial director of Revera and the MOHLTC, revealed the letter had been written on an identified date. Review of the home's CSR form, revealed the DOC received the SDM's written complaint letter on an identified date. Review of progress note on an identified date, revealed the DOC's documentation indicating he/she will send the SDM's written complaint letter to the MOHLTC Director.

Interview with the DOC confirmed he/she received the written complaint letter from resident #001's SDM on an identified date, and he/she forwarded the written complaint letter to the MOHLTC two days later. [s. 22. (1)]

Issued on this 1st day of May, 2017

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

Original report signed by the inspector.