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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2018	2018_684604_0016	012823-17, 013638-18	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

SHIHANA RUMZI (604)

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): November 5, 6, 7, 12, 13, 14, 15, and 16, 2018.

The following complaint intakes were inspected:
Log #: 012823-17, and #013638-18, related to alleged resident neglect, fall, and care not provided in a timely manner.

During the course of the inspection, the inspector(s) spoke with Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI)/ Minimum Data Set (MDS) Coordinator, and Associate Director of Care (ADOC).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, home's complaint log, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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).

Findings/Faits saillants :

The licensee had failed to ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date from an identified person. The identified person stated resident #001 had sustained a fall on an identified date, after the home removed the residents identified devices without their consent, and alleged neglect related to resident #001 being left on an identified date with care not provided.

A telephone interview was conducted on an identified date with an identified person who stated that resident #001 fell on an identified date and location of the home, and was unable to understand how this happened as the resident required staff assistance for identified care. The identified person suggested that the resident may have fallen because the staff did not provide proper care as needed by the resident.

Inspector #604 conducted observations of resident #001 on identified dates and observed the resident in an identified location of the home.

A review of the written plan of care was carried out for an identified period. The written plan of care consisted of an identified focus which directed the staff to ensure that the resident receives care in an identified position, required assistance of two staff, was unable to assist with care, and required two full staff support with total dependence with one staff.

Interviews were conducted on two separate identified dates with Registered Practical Nurse (RPN) #117, and with PSW #119 and #120, who provided care to resident #001. The RPN and PSW staff stated they refer to the written plan of care located on their tablets or the printed plans of care located at the nursing station for care direction. The Inspector reviewed the written plan of care for an identified period for an identified focus with the RPN and the PSW staff separately. The RPN indicated they had provided one to two staff assistance to resident #001 and PSW #120 indicated that they had provided assistance with two staff. PSW #120 further stated resident #001 should be provided two staff assistance with care as the resident is unable to assist with care. The RPN and PSW staff reviewed the written plan of care and acknowledged that there was no clear direction related to how the resident was to receive identified care as the written plan of care stated two staff to for care and then stated the resident required full staff support

total dependence with one staff.

An interview was conducted on an identified date with the Associate Director of Care (ADOC) #105. The ADOC and Inspector #604 reviewed resident #001's written plan of care. The ADOC acknowledged that an identified focus did not provide clear direction to the staff caring for resident #001 as the written plan of care indicated assistance of two staff for care and also indicated the resident required full staff support with total dependence with one staff.

2. The MOHLTC ACTIONline received a complaint on an identified date from an identified person who alleged neglect related to resident #001 not being provided care for hours.

A telephone interview was conducted on an identified date with the identified person. The identified person stated on an identified date when they come to visit resident #001 and indicated resident #001 was in an identified location of the home and they saw no staff in the area and the residents' dignity was not maintained as the resident needed identified care to be provided. The identified person stated they were informed by other staff that PSW #131 was the resident's primary PSW on an identified shift. The identified person stated they spoke to PSW #131 who informed them that they checked and provided identified care to the resident at an identified time, and had not gone back in to check the resident until the identified person had brought it to the PSW's attention that resident #001 needed identified care at an identified time.

Inspector #604 conducted observations of resident #001 on identified dates, observed the resident in an identified location of the home, and was found to be cared for.

A review of the written plan of care was carried out for an identified time period with a focus on identified care needs. The written plan of care consisted of an identified interventions which directed the staff to provide care, total assistance for all identified care needs with two staff, and is on an identified intervention. There was no other information on the written plan of care related to times to provide the intervention to resident #001.

A review of the "Tasks" tab on Point Click Care (PCC) was conducted on an identified date and time period which did not show times for when the identified intervention would be provided to resident #001.

Inspector #604 made several attempts to contact PSW #131 who was a casual staff in the home without success. The home's ADOC and Ward Clerk had also attempted to contact the PSW on several occasions with no success.

An interview was conducted on an identified date with ADOC #105. The ADOC and Inspector #604 reviewed resident #001's written plan of care with an identified date. The ADOC indicated when a resident is on an identified program the written plan of care and the task tab will consist of regular intervals the resident is to be checked. The Inspector and ADOC reviewed resident #001's written plan of care as indicated above and the task tab on PCC. The ADOC acknowledge that there was no clear direction as to when resident #001 was to be provided an identified intervention and would expect resident #001 to be checked often as the resident is dependent of staff for all care needs.

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 that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee had failed to ensure that the plan of care included an order by the physician or the registered nurse in the extended class for an identified safety device.

The MOHLTC ACTIONline received a complaint on an identified date from an identified

person who stated resident #001 sustained a fall on an identified date after the home removed the residents identified safety devices without their consent.

A telephone interview was conducted on an identified date with an identified person who stated on an identified date resident #001 sustained a fall in an identified location of the home and stated that the day of the fall the staff at the home had indicated that the identified safety devices where removed by the home. The identified person indicated they had a conference, and made it clear to the home that they wanted the identified safety devices for resident #001's safety and signed a consent.

Inspector #604 conducted observations of resident #001 on identified dates, and observed the resident in an identified location of the home with the identified safety devices in place.

A review of the current written plan of care with an identified date, consisted of a focus under Power of Attorney (POA) requested the use and application of an identified safety device. The interventions indicated consent had been obtained on an identified date from the identified person for use of the identified safety devices. The interventions indicated that education had been provided to the identified person on the risks with the use of the identified safety devices, and staff were directed to check the resident as indicated on the written plan of care.

A review of the "Physician's Digiorder" was carried out, and the Inspector was unable to find a physician order for the use of the identified safety devices.

An interview was conducted on an identified date with RPN #117, who stated resident #001 utilized an identified safety devices after their fall. The RPN stated a physician order and family consent was to be obtained prior to the use of the identified safety devices. The RPN reviewed resident #001's chart with Inspector and acknowledged that there was no physician order for the use of the identified safety devices. The RPN stated the Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) Coordinator was responsible for obtaining consent and a physician for the use of the identified safety devices.

An interview was conducted on an identified date with the RAI/MDS Coordinator #107 who indicated that when a resident is to utilize identified safety devices a physician order was needed. The RAI/MDS Coordinator reviewed resident #001's chart with the Inspector and acknowledged that there was no physician order for the use of the

identified safety devices for resident #001.

An interview was conducted on an identified date with ADOC #105. The ADOC indicated they were aware that resident #001 utilized an identified safety devices as per family request. The ADOC indicated the home's expectation was that a physician order and family consent was obtained for the identified safety devices. The ADOC reviewed resident #001's chart physician order section with the Inspector and acknowledged that there was no physician order for the identified safety devices for resident #001.

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 the plan of care included an order by the physician or the registered nurse in the extended class for an identified safety device , to be implemented voluntarily.

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.