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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2019	2019_684604_0008	006737-19	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): April 11, 12, 15, 16, 17, 18, 23, 24, 25, 26, 29, 30, and May 1, and 2, 2019.

The following intakes were inspected:
-Critical Incident System (CIS) report, intake log #022251-17, related to resident to resident alleged abuse
-Intake #006737-19, related to an identified resident incident
-intake #006011-19, related to resident not being provided identified care

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), RN Student (RNS), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Skin and Wound Champion (SKC), Behaviour Services Nurse (BSN), Office Manager (OM), Light Duty Housekeeping/Laundry staff (LDHL), residents, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector conducted observations of resident home area, staff to resident interactions, provisions of care, conducted reviews of resident health records, home's complaint and Critical Incident System (CIS) report binder, training records, 2017 and 2018, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
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)**

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. (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 :

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

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date, from complainant #100. The complainant stated resident #001 was not provided identified care.

An interview was conducted with complaint #100, who stated on an identified date, they visited resident #001, and had asked Registered Practical Nurse (RPN) #105 if the resident had their identified care carried out. The RPN had informed the complainant that the care was not carried out as the home did not have the required equipment. The complainant stated on an identified date, when they visited resident #001 the resident was in an identified location and the residents was found to not have been provided the identified care. The complainant indicated they spoke to the Associate Director of Care (ADOC) #101 who indicated the home did not have the equipment needed to provide the identified care. The complainant further indicated they visited the resident on another identified date and time and found the resident to be in an identified location and had been observed with care not provided. The complainant stated the resident was transferred to hospital for further assessment and the identified care was provided once admitted to the hospital.

A review of resident #001's "Physician's Digiorder", was reviewed for an identified period of time and an order was found for identified care to be provided.

A review of resident #001's Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) for an identified time period was carried out. On an identified date the care was not provided as per order.

Interviews were conducted with RPN #103, #105 and #104, RN #110, and RPN #107. The registered staff confirmed that resident #001 was to have identified care provided on identified days of the week. The registered staff indicated the care was not provided as ordered for resident #001.

A review of resident #001's Point Click Care (PCC) progress notes were carried out for an identified period, and progress notes were observed prior to resident being transferred to hospital. The notes indicated that care was not provided on an identified date as the home did not have the equipment required for care.

An interview was conducted with the ADOC #101, who stated that the registered staff is to inform the Director of Care (DOC) or the ADOC if they need identified equipment required for the residents. The ADOC and the Inspector reviewed EMAR/ETAR for resident #001 for an identified time period and the ADOC acknowledged that the care was not provided as ordered for resident #001.

2. During the inspection the home submitted CIS report on an identified date, to the MOHLTC Director, indicating alleged resident to resident abuse had occurred between resident #004 and #005, in an identified location of the home. Resident #005 was found to be in an identified location of the home and resident #004 was observed to be sitting next to the resident exhibiting a responsive behaviour toward resident #005. The CIS report indicated an identified intervention was put into place to keep resident #005 safe.

A review of resident #005's plan of care for an identified date was reviewed, under an identified the focus it directed staff to ensure the identified equipment was in place for the resident.

Inspector #747 conducted observation of resident #005 and noted that the identified intervention was not being followed.

An interview was conducted with RPN #103 who stated that an identified interventions was in place for resident #005 as per the plan of care. The RPN and Inspector carried out observations of an identified intervention in place and it was noted that the intervention was not in place. The RPN acknowledged that the identified intervention was not carried out as per the plan of care.

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 care set out in the plan of care was 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. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

The licensee had failed to ensure that supplies, equipment, and devices were readily available to meet the nursing and personal care needs of the resident.

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date, from complainant #100. The complainant stated they reported alleged neglect of resident #001 as the resident was not provided and identified care on an identified date.

A review of resident #001's "Physician's Digiorder", was reviewed for an identified date. On and identified date the resident was assessed by an identified nurse.

A review of resident #001's "Physician's Digiorder", was reviewed for an identified period of time and an order was found for identified care to be provided.

A review of resident #001's Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) for an identified time period was carried out. On an identified date the care was not provided as per order.

Interviews were conducted with RPN #103, #105 and #104, RN #110, and RPN #107. The Inspector and the registered staff reviewed the "Physician's Digiorders", and the EMAR/ETAR for the identified care. The registered staff acknowledged that during an identified time period they did not have the identified equipment for care to be provided to resident #001.

An interview was conducted with the ADOC #101, who stated that the registered staff is to inform the Director of Care (DOC) or the ADOC if they need identified equipment required for the residents. The ADOC was informed of the above ETAR review and the ADOC acknowledged that the identified equipment was not available as the ADOC and DOC was not informed that the equipment was to be re-ordered.

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.