Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Jun 17, 2020	2020_763116_0010	003405-20	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

SARAN DANIEL-DODD (116)

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): March 12, 13 & June 9, 10, 11, 15, 16, 2020.

Intake log# 003405-20 related to continence care, bowel management and nutritional care were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Associate Director of Care (ADOC), Registered Dietitian (RD), food service manager (FSM), registered staff members (RNs & RPNs), personal support workers (PSWs) and the substitute decision-maker (SDM) of resident #001.
The inspector conducted observations, reviewed resident #001's health record, internal investigation notes and reviewed relevant procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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 :

1. The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #001 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint letter and a submitted Critical Incident Report (CIR) regarding care concerns for resident #001.

Review of the complaint correspondence indicated that resident #001 was observed unattended during an activity of daily living (ADL) with a specified equipment activated and engaged. The correspondence letter further states at the time of observation, staff #109 was present and contacted RPN #104 who was off the unit. Staff #109 no longer works for the home and was unavailable to be interviewed.

Review of the licensee's complaint response indicated an investigation and concern form were completed and a care conference was offered to fully address the care concerns. The complaint response does not document the outcome of the investigation.

A review of resident #001's written plan of care indicated the level of assistance required for specified activities of daily living (ADLs). Resident #001 is identified at risk for falls due to impaired mobility.

During separate interviews with PSW #'s 105 & #106 it was noted that resident #001 requires a specified number of persons for the identified ADL's and supervision during required care tasks.
An interview with PSW #105, indicated resident #001 was placed in a designated area of the unit prior to attending to the care needs of another resident. PSW #105 indicated supervision of resident #001 was delegated to RPN #104 as they could not locate PSW #110.

During an interview with RPN #104, they acknowledged resident #001 was found unattended during a specified ADL on the identified date. RPN #104 indicated resident #001 was situated in a designated area contrary to PSW #105 prior to leaving the unit. RPN #104 acknowledged PSW #105 was providing care to another resident, unaware of the whereabouts of PSW #110 and further indicated resident #001 requires supervision during the specified ADL.

During an interview, E.D. #100 acknowledged that the care set out in the plan of care related to the identified ADL's were not provided to resident #001 as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care related to identified ADL's were provided to the resident as specified in the plan, specifically, resident #001

was found unattended during the identified ADL on the established date. [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 the care set out in the written plan of care was provided to resident #001 as specified in the plan, to be implemented voluntarily.

Issued on this 18th day of June, 2020

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

Original report signed by the inspector.