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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2020	2020_832604_0012	008623-20, 017985-20, 020049-20	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): November 2, 3, 4, 5, 6, 9, 10, 12, and 13, 2020.

During the course of the inspection the following Critical Incident System (CIS) report intakes where inspected:
-Intake related to injury of unknown cause
-Intake related to alleged abuse
-Intake related to fall

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Food Services Manager (FSM), Behavior Support Service Ontario Lead (BSO), Infection Prevention and Control Lead (IPAC), Nurse Practitioner (NP), Registered Nurse (RN), and Personal Support Worker (PSW).

During the course of the inspection the inspector reviewed resident health records, staff to resident interaction, resident room observations, and relevant home policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 the care set out in the plan of care was provided to the resident as specified in the care plan.

A review of the residents' care plan indicated they where at high risk for falls with identified interventions. During an observation it was noted the interventions for fall prevention was not followed. The Registered Practical Nurse (RPN) confirmed the Inspectors observations and stated not following the interventions poses a risk to the resident for further falls.

Sources: residents' care plan, observations, and interview with the RPN.

2. 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 following is further evidence to support the order issued during a past inspection.

A review of the residents' care plan indicated they were at increased risk for impaired skin integrity with identified interventions. During an interview the Director of Care (DOC) indicated through documentation review it was noted a task tab was not created for the identified intervention and during the home's investigation no staff was identified as to not carrying out the care. The DOC stated a Personal Support Worker (PSW) had reported the impaired skin integrity and interventions where not followed. The DOC acknowledges the care set out in the care plan was not provided.

Sources: Critical Incident System (CIS) report, residents' care plan, task report, and interview with the DOC.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the names of any staff members who discovered the incident.

The CIS report submitted did not include the name of the PSW who discovered the resident calling out for assistance post fall. During the interview the DOC reviewed the CIS report and acknowledged the CIS report did not consist of the staff members name who discovered the incident and in closing stated there was no harm to the resident related to this information not being provided to the Director.

Source: Initial and amended CIS reports, interview with PSW, RPN, and DOC.

2. The CIS report did not include the name of the PSW who discovered the impaired skin integrity. During an interview the DOC reviewed the CIS report and acknowledged the CIS report did not consist of the staff members name who discovered the impaired skin integrity and in closing stated there was no harm to the resident related to this information not being provided to the Director.

Source: Initial and amended CIS report, and DOC interview.

3. The licensee has failed to ensure that the report to the Director included actions taken in response to the incident including other authorities who where contacted.

The CIS report did not include information related to contacting other authorities such as the police. A review of the home’s investigation notes indicated the police was contacted and the home was provided with a file number, further review of the home’s investigation notes indicated the police had visited the resident. During an interview the DOC reviewed the CIS report and acknowledged the CIS report did not indicate the police was called and the MLTC Director was not informed and in closing stated there was no harm to the resident related to this information not being provided to the Director.

Sources: Initial and amended CIS report, home’s investigation notes, and DOC interview.

Issued on this 24th day of November, 2020

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

Original report signed by the inspector.