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**

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## 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 9, 2021 | 2021_892762_0008 | 010656-21, 011568-21, 014699-21, 014929-21 | 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

MOSES NEELAM (762), AMANDEEP BHELA (746)

## 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): October 27-29 and November 1-3, 2021**

**During this Critical Incident System (CIS) inspection, the following intakes were reviewed:**
**- Log / CIS related to alleged abuse that lead to an injury of a resident**
**- Log / CIS related to alleged abuse that lead to an injury of a resident**
**- Log / CIS related to an incident that lead to an injury**
**- Log / CIS related to an incident that lead to an injury**

**During the course of the inspection, the inspector(s) spoke with Resident, Assistant Director of Care (ADOC), IPAC Manager, Housekeeping Staff, Registered Nurses (RNs), Registered Practical Nurses (RPN) and Personal Support Workers (PSW)**

**During the course of the inspection, the inspector(s) conducted observations, reviewed resident records, the Long-Term Care Home (LTCHs) policies, and toured resident units**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that PSW #113 used safe transferring and positioning techniques when assisting resident #007.

A Critical Incident Report (CIR), was submitted to the director related to an unknown injury. The CIR indicated that the investigation did not indicate how the resident got the injury. A review of investigation notes indicated that PSW #113 had conducted a single person transfer using a mechanical lift prior to the incident, but did not conclude whether the injury was a result of the transfer. In separate interviews, PSW #113 and ADOC #106 indicated that this was unsafe for the resident. As a result, the resident was put at risk for injury due to the use of the lift independently.

Sources: Investigation notes; CIR; Interviews with PSW #113 and ADOC #106 [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that RPN #116 who had reasonable grounds to suspect abuse of resident #007 by anyone or staff that resulted in risk of harm for the resident, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR), was submitted to the director related to unknown injury that occurred a few days prior to the submission of the CIR. A review of resident #007's progress notes indicated that abuse of the resident was suspected a few days prior to the submission of the CIR by RPN #116. In an interview ADOC #106 indicated that the CIR was submitted late as the management team was informed late. There was no risk to the resident as a result of the late submission of the CIR.

Source: CIR; Interview; progress notes; Interview with ADOC #106 [s. 24. (1)]

**Issued on this 9th day of November, 2021**

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

**Original report signed by the inspector.**