Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: April 9, 2024

Inspection Number: 2024-1378-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

Long Term Care Home and City: Sherwood Court Long Term Care Centre, Maple

Lead Inspector	**Inspector Digital Signature**
Nicole Lemieux (721709)	Nicole S Lemieux Digitally signed by Nicole S Lemieux Date: 2024.04.19 11:37:59 -04'00'

Additional Inspector(s)
Suzanna McCarthy (000745)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18 to 22 and 26, 2024
The inspection occurred offsite on the following date(s): March 25, 2024

The following intake(s) were inspected:

- Intake: #00104575 – First Follow-up to Compliance Order #001 from Inspection #2023_1378_0003- FLTCA, 2021, s. 5, with a Compliance Due Date (CDD) February 7, 2024

- Intake: #00104576 -First Follow-up to Compliance Order #002 from Inspection #2023_1378_0003 - FLTCA, 2021, s. 24 (1), with a CDD February 7, 2024
- One intake related to a resident-to-resident physical altercation resulting injury.
- One intake related to a complaint regarding concerns of neglect, recreation activities, plan of care, skin and wound, improper medication administration, responsive behaviors, and unlawful discharge.
- One intake related to visitor to resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1378-0003 related to FLTCA, 2021, s. 5 inspected by Nicole Lemieux (721709)

Order #002 from Inspection #2023-1378-0003 related to FLTCA, 2021, s. 24 (1) inspected by Suzanna McCarthy (000745)

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Recreational and Social Activities
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: REQUIREMENTS ON LICENSEE BEFORE DISCHARGING A RESIDENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee failed to ensure that a resident or their Substitute Decision Maker (SDM) were provided with advanced notice of a resident's discharge from the home.

Rationale and Summary

A resident was involved in an incident during which there was physical aggression between the resident and a family member, leading to outside authorities being called to the long-term care home (LTCH) to assist with intervention. The resident had a significant history of responsive behaviours with escalating aggression prior to this incident for which the LTCH had trialed a variety of interventions including engaging external supports and the resident's SDM.

The Director of Care (DOC) and Assistant Director of Care (ADOC) reported that following the incident, the resident's physician engaged in medical assistance outside of the LTCH to which resulted in the transfer to another medical facility. The ADOC and Executive Director (ED) both reported that immediately after the incident,

the LTCH's Nurse Practitioner (NP) was notified of the residents transfer and discharge and confirmed that it had been reported to the medical facility, though the discharge was not reported to the resident's SDM.

The following day after the incident, the resident returned to the LTCH in the care of their SDM. The SDM indicated that the resident had completed their treatment and was being returned to the LTCH for re-entry to the home. At this time, the SDM was notified by the ED via telephone that the resident had been discharged from the LTCH and to the care of another medical facility. The resident was refused re-entry to the home. The ED reported that they offered to call for assistance to have the resident returned to the medical facility for care as an interim measure pending the conference scheduled to take place two days later. The ED and ADOC further reported that while the home had not provided advance notice of the discharge to the SDM, it was their intention that the SDM would be notified of the discharge at the meeting scheduled for three days after the transfer of the resident at which point all relevant parties and supports would work with the SDM and the LTCH to determine the best course of action to support the resident.

While the SDM was still on site with the resident the day after the incident, they were provided with an unsigned copy of a discharge letter which was dated the day prior. Prior to the discussion between the SDM and LTCH staff on site the day of the residents return, the SDM was unaware that the resident had been discharged. The SDM exited the LTCH with the resident in their care. The ED confirmed that they did not have a letter prepared prior to the SDM's arrival at the LTCH and stated that this was because the LTCH believed that the resident would be in the care of the medical facility until the scheduled meeting. They also stated that they had reviewed the legislation and believed that as long as the resident was not being discharged to homelessness, the discharge was permitted.

Failure to provide advanced written notice to the resident and their SDM eliminated the opportunity to arrange for immediate care alternatives for the resident upon discharge.

Sources: interviews with staff, interview with the resident's SDM, a resident's clinical records. [000745]