Ontario

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

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

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

Original Public Report

Report Issue Date: May 23, 2024	
Inspection Number: 2024-1378-0003	
Inspection Type: Proactive Compliance Inspection	
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 Nicole Lemieux (721709)	**Inspector Digital Signature**
Additional Inspector(s) Ana Best (741722)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 to 10, and 13 to 16, 2024.

The following intake(s) were inspected:
- One intake related to a Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

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Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure that a resident was provided with an assistive device required to safely drink as comfortably as possible.

Rationale and Summary

During an observation in the dining room, a resident was served using regular utensils. The resident's care plan indicated they required a specific device during

the mealtime. The Long-Term Care Home's (LTCH) policy indicated that as part of the interventions, appropriate techniques for safe eating and feeding including specific devices, were to be implemented for all residents according to their individual plan of care.

Personal Support Worker (PSW) #104 and Dietary Aid (DA) #107 indicated the resident was to use a specific device during the meal, and this intervention was not followed during the observed lunch service.

The Food Services Manager (FSM) indicated it was the responsibility of the DA and PSW assisting with the resident's feeding to ensure specific devices were used as directed in the resident's care plan.

Failure to ensure the resident was provided with the appropriate specific device, placed the resident to an increased risk for discomfort, or other complications.

Sources: Observations, the resident's health records, LTCH's Dysphagia Management and Safe Eating policy, and interviews with staff. [741722]

WRITTEN NOTIFICATION: INFECTION AND PREVENTION CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard issued by the Director was followed related to additional precautions specifically the application of personal protective equipment (PPE).

In accordance with the IPAC Standard for LTCH's issued by the Director, updated September 2023, under section 9.1 (f), the licensee shall ensure that additional precaution requirements including the appropriate section and application are followed.

Rationale and Summary

Resident #009 required additional precautions as indicated by signage on their bedroom door. Both the resident's clinical records and a list provided by the home confirmed the same. Inspector #721709 observed PSW #106 enter resident #009's room without donning the appropriate PPE. The PSW was observed to be within two meters of the resident while assisting the resident. The home's additional precaution policy indicated that specific PPE was to be worn within two meters of a resident on additional precautions.

The IPAC Lead and PSW confirmed that it was the expectation of the staff to apply the appropriate PPE prior to entering a resident's room who required additional precautions.

Failing to wear appropriate PPE when resident #009 was on additional precautions may result in further spread of infectious diseases.

Sources: Observations, resident #009's clinical records, list of residents on isolation/additional precautions, Additional Precautions policy, and interviews with PSW #106 and the IPAC Lead. [721709]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in an area or medication cart that was secured and locked.

Rationale and Summary

Inspector #721709 observed an unlocked medication cart parked across from the nursing station on a resident home area. During this observation, no registered staff were visible in the immediate area surrounding the medication cart and several residents were noted to be seated and ambulating in the same area. After several minutes, Registered Nurse (RN) #119 exited a resident's room and returned to the unlocked medication cart. The home's "Medication Administration" policy confirmed that the medication cart was to be locked at all times when unattended or out of sight of the nurse.

The RN and the Director of Care (DOC) confirmed that the medication cart was left unlocked while unattended and that the home's expectations was to lock the cart at all times when being left unsupervised.

Failure to keep the medication cart locked when unattended posed a risk to the safety and well-being of residents.

Sources: Observations, Medication Administration policy, and interviews with RN #119 and the DOC. [721709]