Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 28, 2018	2018_486653_0029	008799-17, 009221-17, 009681-17, 010665-17, 016555-17, 026777-17, 013139-18, 014545-18	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

ROMELA VILLASPIR (653), 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 5, 6, 7, 8, 9, 13, 14, 15, and 16, 2018.

The following Critical Incident (CI) intakes had been inspected concurrently:

The following intakes related to falls:
Log #(s): 009221-17, 009681-17, 010665-17, 026777-17, 013139-18, 014545-18.

Log #008799-17 related to abuse, and Log #016555-17 related to unsafe transfer.

During the course of the inspection, the inspector conducted observations of care provision to residents, staff to resident interactions, reviewed the home's staffing schedule, staff training records, clinical health records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Staff Relief Agency RNs, Physiotherapist (PT), Resident Assessment Instrument (RAI)/ Minimum Data Set (MDS) Co-Ordinator, Program Manager and Volunteer Coordinator (PMVC), Associate Director of Care (ADOC), Previous Director of Care (PDOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date and time, the home had submitted a Critical Incident Report (CIR) to the Director, for alleged abuse. The CIR indicated a manager reported they had witnessed a Personal Support Worker (PSW) trying to wake up the resident inappropriately during an identified meal service.

A review of the home's investigation notes revealed the Previous Director of Care (PDOC)'s handwritten note of their review of the home's video surveillance from the date and time of the incident identified in the CIR.

The Executive Director (ED) indicated to Inspector #653 that they could not retrieve the video footage of the incident.

An interview with PSW #123 indicated they had worked on the identified shift and was assigned to resident #013's care. During the identified meal service, PSW #123 was about to feed resident #013, however, they were sleeping. The PSW called out the resident's name, held them on their identified part of the body, and the resident woke up. The PSW further indicated their intention was to wake up the resident to eat, and not to harm them.

A telephone interview with the Program Manager and Volunteer Coordinator (PMVC), indicated during the identified meal service, they remembered walking to the dining room and had seen PSW #123 feeding the resident. The PMVC perceived PSW #123's body language to be inappropriate towards resident #013, and reported it to the previous ED.

A telephone interview with the PDOC indicated they were made aware of the above mentioned incident through a staff member reporting to them. The PDOC reviewed the home's video surveillance and stated the PSW was trying to wake up the resident and was inappropriate as observed in the video footage. The PDOC further indicated as a result of the incident, the home investigated and PSW #123 had been removed from resident #013's care. The PDOC stated that PSW #123 did not respect and promote resident #013's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and the resident's dignity.

A telephone interview with Registered Nurse (RN) #103, indicated they did not witness the incident but was immediately told by the PDOC at that time to come for a meeting and discuss the incident. PSW #123 was not available in the home and RN #103 completed a head to toe assessment and did not find any injury. The RN further indicated resident #013's Substitute Decision-Maker (SDM), the physician, and the police were notified of the incident.

An interview with the Associate Director of Care (ADOC) acknowledged that resident #013's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and the resident's dignity, had not been fully respected and promoted by PSW #123 in the above mentioned incident.

The licensee had failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

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 following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg 79/10, s. 30 (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

According to O. Reg 79/10, s. 49 (1), The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of the home's policy titled "Fall Prevention and Injury Reduction" policy #CARE5-O10.05 effective 2017, indicated under procedure for post-fall management, that a post-fall assessment is completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours. If a fall is unwitnessed or the resident was witnessed hitting their head during the fall, the Head Injury Routine (HIR) is

initiated, and neurovitals are monitored for 72 hours.

On an identified date and time, the home had submitted a CIR to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #011 had six falls in the home between an identified time period, and the family had decided to transfer resident #011 to the hospital for further assessment.

A review of Registered Practical Nurse (RPN) #102's progress note from an identified date and time, indicated resident #011 was found lying on the floor in their room and verbalized several times they did not fall. There were no injuries noted and the resident verbalized they were cold and in pain.

A telephone interview with RPN #102 indicated they had worked during the identified shift, and at an identified time PSW #100 had called them to go to resident #011's room as the resident was found on the floor. RPN #102 attended to the resident and found them on the floor, in their bedroom. The RPN stated the PSW had told them resident #011 exhibited an identified behaviour, and had assumed the resident did not fall. The RPN confirmed they did not complete a post-fall assessment including the HIR on the resident as required by the home's policy.

An interview with the ADOC indicated when they came to the home the following day and reviewed the 24hr report, they had noticed RPN #102's documentation related to resident #011, from the identified shift. The ADOC stated they had constituted the incident as an unwitnessed fall based on the progress note, and they did not find a post-fall assessment and HIR initiated for the fall. The ADOC further acknowledged RPN #102 did not carry out a post-fall assessment including the HIR immediately following the fall as required by the home's policy.

The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: 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 had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date and time, the home had reported to the Director through the Ministry of Health and Long-Term Care (MOHLTC)'s After Hours Pager that resident #003 sustained an alteration in skin integrity in their identified part of the body. The resident stated they bumped themselves on an identified assistive transfer device during a transfer the day prior. The resident further indicated there was only one PSW during the time of the transfer. As per the facility's requirement, two staff must be present when the identified assistive transfer device was used. The PSW did not immediately report the incident to the home.

On an identified date and time, the home had submitted a CIR to the Director, for improper/ incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated a PSW reported that they had found two new alterations in skin integrity on resident #003 on an identified part of the body. The resident had stated the bruises were caused by the identified assistive transfer device. The CIR further indicated the home initiated an investigation.

A review of resident #003's written plan of care from an identified date, indicated resident #003 required the use of the identified assistive transfer device with two staff for all transfers.

A telephone interview with PSW #124 indicated they worked on the identified shift and were assigned to resident #003's care. PSW #124 further stated at that time, the resident needed to go to the bathroom and the PSW was unable to get assistance from co-workers. The PSW indicated they waited for ten minutes and transferred the resident using the identified assistive transfer device unassisted as no staff was available to assist. The PSW acknowledged that they did not follow safe transfer process for resident #003.

An interview with the ADOC indicated the staff in the home had been provided with education along with the home's policy related to the identified assistive transfer devices. The ADOC indicated they do recall the incident involving resident #003 and that unsafe transfer was carried out by PSW #124. [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.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that when the resident had fallen, the resident had been assessed, and if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On an identified date and time, the home had submitted a CIR to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #011 had six falls in the home between an identified time period, and the family had decided to transfer resident #011 to the hospital for further assessment.

A review of the home's policy titled "Fall Prevention and Injury Reduction" policy #CARE5-O10.05 effective 2017, indicated under procedure for post-fall management, that a post-fall assessment is completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours.

A review of RPN #102's progress note from an identified date and time, indicated resident #011 was found lying on the floor in their room, and verbalized several times

they did not fall. There were no injuries noted and the resident verbalized they were cold and in pain.

A telephone interview with RPN #102 indicated they had worked during the identified shift, and at an identified time PSW #100 had called them to go to resident #011's room as the resident was found on the floor. RPN #102 attended to the resident and found them lying on the floor, in their bedroom. The RPN stated the PSW had told them resident #011 exhibited an identified behaviour, and had assumed the resident did not fall. The RPN stated it was an error in judgement and confirmed they did not complete a post-fall assessment as required.

An interview with the ADOC indicated when they came to the home the following day and reviewed the 24hr report, they had noticed RPN #102's documentation related to resident #011, from the identified shift. The ADOC stated they had constituted the incident as an unwitnessed fall based on the progress note, and they did not find a post-fall assessment for the fall. The ADOC further acknowledged RPN #102 did not carry out a post-fall assessment including the HIR immediately following the fall.

The licensee had failed to ensure that when resident #011 had fallen, the resident had been assessed, and if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 28th day of November, 2018

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

Original report signed by the inspector.