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
May 28, 2019	2019_684604_0009	027625-18, 027673-18, 027749-18	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): April 11, 12, 15, 16, 17, 18, 23, 24, 25, 26, 29, 30, and May 1, and 2, 2019.

The following complaint intakes were inspected:
-Intake #027625-18, related to resident not being provided an identified care and agency staff not being trained in the home's processes.
-Intake #027749-18, and #027673-18, related to resident not receiving care in a timely manner related to short staffing and agency staff not being trained.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Personal Support Worker (PSW), Resident Services Manager (RSM), Behaviour Services Nurse (BSN), Office Manager (OM), Ward Clark (WK), Gem Health Care Services Operations Manager (GHCSOM), Gem Health Care Services PSW, Tranquil Care Agency (TCA), Light Duty Housekeeping/Laundry staff (LDHL), residents, and Power of Attorney (POA).

During the course of the inspection, the inspector conducted observations on staffing on the home areas, staff to resident interactions, provisions of care, conducted reviews of resident health records, home's complaint and Critical Incident System (CIS) report binder, training records, 2017 and 2018, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Training and Orientation

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 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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that all staff have received training in the following areas before performing their responsibilities:
1. The Residents' Bill of Rights
2. The home's mission statement
3. The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
5. The whistle-blower protections under section 26
6. The home's policy to minimize the restraining of residents
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities
11. Any other areas provided for in the regulations

Regulations s.74 (1) (2) defines "agency staff" as staff who work at the long-term care home pursuant to a contract between the license and an employment agency or other third party.

The MOHLTC ACTIONline received two complaints on two identified date and the complainant stated that agency Personal Support Worker (PSW) staff working in the home are not educated, lack orientation, and training prior to starting at the home.

An interview was conducted with complainant #008 & #012, separately. Both complainants stated that the during an identified period there were many agency PSW staff in the home who were not orientated to the home's processes and were not able to provide care to residents as required and were unaware of their duties.

Inspector #604 reviewed the home's records of the training booklet for Spartan Health Care, Tranquil Care, and Gem Health Care Services for an identified period of time along with the staffing daily schedule. Five agency staff where found to have not received training on the home's processes.

An interview was carried out with home's Resident Services Manager (RSM) #122 who indicated that all agency staff prior to working on the home receive training and orientation on the above required topics as indicated in the Legislation prior to their assigned shift along with providing access to residents plan of care and orientation on lifts on the unit. The RSM indicated training/orientation booklets are provided to the agency staff and reviewed by the RSM or the Charge Nurse (CN) two to three hours prior to the agency staff starting their shift on the assigned unit. Once the training/orientation booklets where completed the agency staff the RSM or CN will sign the booklet and the booklets are filed in the home.

Inspector #604 reviewed the home's records of the training/orientation booklet records for Spartan Health Care, Tranquil Care, and Gem Health Care Services and the RSM acknowledged there was no evidence that the five agency staff received training prior to performing their responsibilities in the home and they were missed.

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 all staff have received training in the following areas before performing their responsibilities:
1. The Residents' Bill of Rights
2. The home's mission statement
3. The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
5. The whistle-blower protections under section 26
6. The home's policy to minimize the restraining of residents
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities
11. Any other areas provided for in the regulations,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee had failed to ensure that the resident who was incontinent have an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and has that plan implemented.

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date. The complainant stated that resident #013 required staff for

identified care. The complainant stated they had informed staff resident #013 needed an identified care which was not provided in the past. The complainant further stated that the same incident occurred on an identified date and shift and the complainant had to provide the identified care to resident #013 on their own.

The home submitted a Critical Incident Systems (CIS) report on an identified date to the MOHLTC Director reporting an allegation of neglect by resident #013's family related to the resident not being provided an identified care in a timely manner.

An interview was conducted with complainant#144 who stated that an identified care was an ongoing issue as resident #013 required an identified number of staff for care. The complainant stated the resident did not receive the identified care when requested on an identified date and shift. The complainant indicated they had approached the primary PSW #118 twice and Registered Staff (RN) #119 once on an identified shift and informed them the resident required an identified care. The complainant stated after no staff attended to the resident the complainant provided the identified care to the resident.

A review of resident #013's plan of care with a last care plan review completed date was carried out. Under an identified focus it indicated the resident is to be provided with an identified interventions in an identified number of staff.

Interviews were conducted with the Behaviour Support Services (BSS) nurse #108, Personal Support Worker (PSW) #117 and #118, with Registered Nurse (RN) #119, and PSW #131. The staff indicated resident #013 required an identified number of staff for an identified care. Inspector #604 reviewed the above identified plan of care with the staff related to resident #013's identified care needs. The BSS, RN, and PSW staff acknowledged that the plan of care was not individualized for resident #013's identified care need.

An interview was conducted with Associate Director of Care (ADOC) #101, who reviewed the plan of care. The ADOC acknowledged the plan of care for resident #013 did not provide for an individualized plan related to an identified care required by the resident.

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.