Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 25, 2019	2019_763116_0004	012089-19, 017895-19	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

SARAN DANIEL-DODD (116)

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 24, 28, 29, 30, 31 & November 4, 2019.

The following intakes were inspected:
Log #012089-19 related to falls prevention and management and,
Log #017895-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), director of care (DOC), associate director of care (ADOC), registered nurses (RNs & RPNs), personal support workers (PSW) and residents.
The inspector conducted observations, reviewed residents' health records, internal investigation notes, staff training records, and reviewed any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from emotional and

verbal abuse by anyone.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

"verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date, reporting an incident of staff to resident abuse.

The CIS report detailed the following:
On a specified date, resident #003 stated to a member of management that a staff member made rude comments to another co worker referring to resident #003. Resident #003 also stated that on another occasion, the same staff member answered the resident's call bell upon requesting to go to the bathroom. The staff member directed the resident to void in bed of which resident #003 refused.

Review of the written plan of care, under continent focus documents that resident #003 is fully continent, requires support with transfers due to an identified medical condition and requires the use of a mechanical lift with two person assistance.

During an interview with resident #003, they expressed that they were initially scared and that the verbal comments and directions made by the identified staff member made them feel less than a person.

A review of the home's internal investigation notes and interviews with identified members of the management team indicated that an internal investigation was initiated. The identified staff member was placed on an administrative leave upon the incident being reported. The home arranged a meeting to be held with the staff member in question however, the staff member failed to attend and forwarded notification of resignation.

Interviews held with members of the management team indicated that under the home's zero tolerance for abuse and neglect policy; they adhere to the Ministry's definition of emotional abuse and that this incident constitutes as emotional abuse. Identified members of the management team acknowledged that emotional and verbal abuse occurred when the identified staff member was emotionally and verbally abusive to resident #003 on a specified date. [s. 19. (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 resident #003 is protected from emotional and verbal abuse by anyone, to be implemented voluntarily.

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.