

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
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 23, 2020	2020_832604_0011	013787-20, 018598-20	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): November 2, 3, 4, 5, 6, 9, 10, 12, and 13, 2020.

During the course of the inspection the following complaint intakes were inspected:

- Intake related alleged abuse**
- Intake related to alleged abuse and staffing**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Food Services Manager (FSM), Behavior Support Service Ontario Lead (BSO), Infection Prevention and Control Lead (IPAC), Nurse Practitioner (NP), Registered Nurse (RN), and Personal Support Worker (PSW).

During the course of the inspection the inspector reviewed resident health records, staff to resident interaction, daily staffing schedule, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

- Critical Incident Response**
- Hospitalization and Change in Condition**
- Prevention of Abuse, Neglect and Retaliation**
- Sufficient Staffing**

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

- 2. A description of the individuals involved in the incident, including,**
- i. names of any residents involved in the incident,**
 - ii. names of any staff members or other persons who were present at or discovered the incident, and**
 - iii. names of staff members who responded or are responding to the incident.**
- O. Reg. 79/10, s. 107 (4).**

Findings/Faits saillants :

The licensee has failed to ensure that the licensees report to the Director included the names of any staff members who discovered the incident.

The Critical Incident System (CIS) report submitted did not include the names of the staff members who discovered the change in resident health status. During the interview the Director of Care (DOC) reviewed the CIS report and acknowledged the CIS report did not consist of the staff members who discovered the incident.

Sources: CIS, progress note review, and interview with DOC.

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 ensure that the licensees report to the Director included the names of any staff members who discovered the incident, to be implemented voluntarily.

Issued on this 24th day of November, 2020

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

Original report signed by the inspector.