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

Central East Service Area Office
33 King Street West, 4th Floor
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Original Public Report

Report Issue Date August 4, 2022
Inspection Number 2022_1273_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________

Licensee
AXR Operating (National) LP, by its general partners

Long-Term Care Home and City
Sherwood Court LTC Centre, Maple

Lead Inspector
Amandeep Bhela(746)

Inspector Digital Signature

Additional Inspector(s)
Asal Fouladgar (751)

Sarah Lee (735818), Rexel Cacayurin(741749), Najat Mahmoud (741773), Fatemeh Heydarimoghari (742649), and Ana Best(741722) were present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27, 28, 29, 30, July 4, 5, 6, 7,8, 11, 2022.

The following intake(s) were inspected:

- Intake # 010867-22 related to Staffing
- Intake # 010827-22 related to Infection Prevention and Control (IPAC), Staffing
- Intake # 010757-22 related to IPAC, Staffing
- Intake # 010754-22 related to IPAC, House keeping
- Intake # 010407-22 related to Neglect
- Intake # 010052-22 related to Falls, Neglect, IPAC
- Intake # 010029-22 related to Neglect
- Intake # 009621-22 related to Pest Control, Housekeeping, IPAC
- Intake # 008620-22 related to COVID-19 Outbreak, IPAC

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22 s. 79 (1) 3

The licensee failed to ensure the monitoring of all residents during meals.

Rationale and Summary

An observation was conducted on a Resident Home Area (RHA), where there was no registered staff present during breakfast service, monitoring the dining room. Registered Practical Nurse (RPN) #120 was observed down the hallway administering medications, with no sight of the dining room. At 0915 hours (hrs), Associate Director of Care (ADOC) #103 arrived in the dining room and spoke with RPN #120. RPN #120 was then observed to monitor the remainder of the dining service.

RPN #120 and ADOC #103 indicated that the expectation at the home was for a registered staff member to be present during meal service to monitor the residents. ADOC #103 further indicated that they had provided RPN #120 education on the spot and asked them to monitor the remainder of the meal service. They indicated the risk in not having a registered staff member present in the dining room, was potential delay in responding to emergencies such as a resident choking during a meal.

Date Remedy Implemented: July 7, 2022 [746]

WRITTEN NOTIFICATION [DOORS IN A HOME]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.12 (1) (3)

The licensee failed to ensure that the spa room door on RHA, and linen closets on all home areas were kept closed and locked when not being used by staff.

Rationale and Summary
During an observation on June 28, 2022, Inspector #751 noted the spa room door on RHA was opened. A note placed on the door indicated, “Please keep the door closed at all times”. Upon further observation, inspectors noted sharps and mechanical lifts were easily accessible and a staff member who passed by did not attempt to close the door. A resident was noted wandering in the hallway and passed by the spa room.

Personal Support Worker (PSW) #105 stated that the spa room door must be closed and locked when unsupervised to ensure the safety of the residents. PSW #105 also stated that resident’s mechanical lifts were stored in the spa room and they closed the door immediately and pushed it to make sure the door was locked.

Inspector #746 observed a linen closet door on an identified RHA that was not completely closed. When asked by the inspector, RPN #121 attempted to lock the door without success. Then, the RPN adjusted the latch and was able to successfully lock the door.

Additional observations were conducted in the home and it was observed that seven non-residential closets, were not locked by staff, on RHA’s.

ADOC #103 and Environmental Service Manager (ESM) confirmed that the door’s were not locked, staff were provided education on how to lock the doors and signage was posted on the doors with instructions on how to lock the doors. The DOC confirmed that staff must ensure the spa room doors were kept closed and locked at all times for residents’ safety.

There was potential risk to the residents as the sharps and mechanical lifts were easily accessible in the spa room and care carts were stored in the linen closets.

Sources: Observations, Interviews with PSW #105, RPN# 121, ADOC#103, ESM and DOC.

[751] [746]

WRITTEN NOTIFICATION [CMOH AND MOH]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1
Non-compliance with: O. Reg. 246/22 [s. 272]

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Rationale and Summary

As per COVID-19 guidance document for long-term care homes in Ontario, homes must ensure that all staff, students, volunteers and visitors (general or essential) wear a medical

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mask for the entire duration of their shift or visit indoors regardless of their immunization status (including in the resident's room). These requirements also apply regardless of whether the home was in an outbreak or not.

Essential visitor #112 was observed wearing their mask on their chin. Essential visitor #112 applied their mask properly upon seeing inspectors and stated they were aware of the home's infection prevention and control (IPAC) policy and had received training from the home regarding IPAC measures.

Essential visitor #113 was observed not wearing their mask properly as it was placed below their nose. They indicated they were aware of the home's policy related to masking and immediately applied their mask properly.

The home's IPAC manager indicated that the visitors were supposed to wear their mask properly at all times.

There was a risk to the residents and other staff of the home when the above essential visitors were not wearing their mask properly due to transmission of infectious agent, such as, COVID-19 virus as the home was in a COVID-19 outbreak.

Sources: Observations, interviews with essential visitor #112, essential visitor #113, and IPAC Manager, COVID-19 guidance document for long-term care homes in Ontario, updated on June 28, 2022.

[751]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 [s. 6 (1) (c)]

The licensee has failed to ensure that a resident's written plan of care set out clear direction to staff.

Rationale and Summary

A resident's care plan in Point Click Care (PCC) documented specific instructions to prepare meals.

The resident's plan of care documented in Meal Suit System utilized by dietary aid staff indicated different instructions to prepare meals.

Dietary aide (DA) #114 and the Food Service Manger (FSM) stated that the resident's nutritional needs information must be identical in both PCC care plan and Meal Suit System as they both were considered the resident's plan of care.

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FSM confirmed the resident's plan of care did not set out clear direction with regards to their nutritional needs.

There was a risk to the resident when their care plan did not set out clear direction with regards to their dietary and nutritional needs.

Sources: resident's PCC care plan and information documented in Meal Suit System, interviews with DA #114 and FSM.

[751]

WRITTEN NOTIFICATION [PEST CONTROL]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 94 (2)

The licensee failed to ensure that immediate action was taken to deal with pests in the home.

Rationale and Summary

Observation conducted on two different dates indicated the presence of ants in two different areas of the home.

The home's pest control inspection report conducted by ABELL Pest Control company, indicated the home had one pest activity categorized as cautionary finding and one structural finding categorized as critical finding. The report further noted structural recommendation in their previous inspection, was not yet addressed by the home.

The ESM confirmed that the home did not address the recommendation, by ABELL pest control company.

Failure to address the ABELL Pest Control company recommendations increased the risk of pest infestation in the home.

Sources: observations, interview with ESM, review of the pest control inspection report conducted by ABELL Pest Control company.

[751]

WRITTEN NOTIFICATION [ACCOMODATION SERVICES]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.19 (2) a

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

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Rationale and Summary

A complaint was submitted to the Director, related to concerns around the resident dining room not being cleaned after meals resulting in food debris being left on the floor.

The home's investigation and ESM confirmed that the dining room had not been cleaned thoroughly after lunch resulting in food debris being left on the floor. The ESM further indicated that the housekeeping staff was from agency and was not scheduled to work at the home again. A Public Health Inspection was conducted by York Region Public Health, which documented that two out of the three dining room floors upon inspection had food debris, mashed potatoes and napkins on the floor. The inspection indicated that they had advised the home to prioritize the cleaning and disinfection immediately after spills with the home.

Failure to ensure that the home's resident dining areas were kept clean and sanitary may negatively affect residents' quality of dining experience and may negatively impact the home's infection control practices.

Sources: Record review of home's investigation, public health inspection and interviews with ESM and Public Health Inspector. [746]

WRITTEN NOTIFICATION [COOLING REQUIREMENTS]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s.23 (7)

The licensee failed to ensure that on or before June 22, 2022, all resident bedrooms were served by air conditioning.

Rationale and Summary

The Executive Director (ED) provided the home's resident listing report which identified the resident's rooms with air conditioning installed. The records indicated that as of June 27, 2022, the home had eight resident rooms served with air conditioning.

The ESM and ED indicated that they were working on installing the air conditioning units in the remainder of the resident rooms. They further indicated they were not aware that all the units had to be installed by June 22, 2022, as they had been awaiting the arrival of the air conditioning units on site. The ED confirmed that no request for exemption was submitted to the Director.

Failing to implement air conditioning in resident rooms increased the chances of risk of associated with elevated heat and humidity.

Sources: Resident Listing Report and Interviews with ESM and Executive Director. [746]