Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Original Public Report

Report Issue Date: July 27, 2023	
Inspection Number: 2023-1378-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Sherwood Court Long Term Care Centre, Maple	
Lead Inspector Jennifer Brown (647)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Lemieux (721709)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26, 27, 29, 30, 2023 and July 4, 5, 6, 7, 2023.

The following intake(s) were inspected:
- Five intakes related to staff to resident abuse,
- Five intakes related to falls,
- Three intakes related to an injury of unknown cause,
- Two intakes related to a medication incident,
- Two intakes related to resident to resident abuse,
- One intake related to staff to resident neglect,
- One intake related to neglect and wound care, and
- One intake related to an injury to a resident, availability of supplies, reporting.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Transferring

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

The home submitted a Critical Incident Report (CIS), which indicated that a resident was improperly transferred during care by a direct care staff member. The CIS further indicated that later the same shift, the resident was observed with an injury to their upper body and subsequently diagnosed with an identified fracture.

The Director of Care (DOC) indicated that during the home's investigation, the direct care staff member denied any incident that could have contributed to the resident's injury, however, did admit to providing the resident with safe transferring assistance.

Failure to transfer a resident in a safe manner posed a risk to the resident for injury.

Sources: CIS, home's investigation, interviews with the DOC, and other staff. [647]

WRITTEN NOTIFICATION: Heat related illness prevention

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

Non-compliance with: O. Reg. 246/22, s. 23 (4) (a)

The licensee failed to ensure that the heat related illness prevention and management plan for the home was implemented for a resident on a day between May 15 to September 15, on which the outside temperature was forecasted at 26 degrees Celsius or above at any point during the day.

Rationale and Summary

A complaint was made to the Director related to a concern regarding a resident being left outside for an extended period of time on a day with a heat advisory that resulted in a transfer to hospital. Documentation confirmed that the resident was monitored by staff via the window, however, the resident's care plan identified the resident was to be provided extra fluids between meals. Emergency room consult notes confirmed that the resident had experienced hyperthermia and dehydration as a result of being left outside in the heat.

Review of the temperatures for the identified date indicated that the temperature was 28 degrees Celsius. The home's policy "LTC - Heat Related Illness" indicated that the interdisciplinary Heat Response Plan would be a home specific plan to address risk for heat-related illness and that all residents were considered to be at risk. Both the Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed that resident's heat risk is identified on their care plan, including interventions and that on heat advisory days staff were to provide extra fluids to all residents.

The resident indicated that no staff prior to leaving or while they were outside offered or provided fluids. Staff indicated that it was the home's expectations to go outside and check on the resident as well as offer fluids.

Failing to ensure that the heat related illness prevention and management plan was implemented for the resident put the resident at risk for complications related to heat related illnesses.

Sources: Resident's clinical health records, Weather report in Vaughan, Ontario, Canada (timeanddate.com) website, the home's "LTC - Heat Related Illness" policy, CARE 10-010.09, interviews with direct care staff, ADOC and DOC. [727109]

WRITTEN NOTIFICATION: Medication Administration

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug is used by or administered to a resident unless the drug has been prescribed for them.

Rationale and Summary

The home submitted a Critical Incident Report (CIS), which indicated that a resident received a medication without a doctors' order.

Registered staff indicated when entering doctor's orders to submit to pharmacy, they transcribed the doctor's order into the resident's chart in error which led to the resident receiving a medication that had not been prescribed to them for four days.

Failure to transcribe the medication in the correct resident chart posed a risk to the resident for experiencing an adverse drug reaction.

Sources: CIS, medication incident report, electronic medication administration report (eMAR), and interviews with Registered staff, and other staff. [647]