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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 7, 2023

Inspection Number: 2023-1378-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

Long Term Care Home and City: Sherwood Court Long Term Care Centre, Maple

Lead Inspector	**Inspector Digital Signature**
Diane Brown (110)	Diane Brown Digitally signed by Diane Brown Date: 2023.12.22 11:35:48 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6 -10, 12, 14 - 17, 2023

The following intake(s) were inspected:

- Intake: #00095234 - critical incident reporting a resident fall resulting in a significant change in status.
- Intake: #00099477 - critical incident reporting an unexpected death of a resident.
- Intake: #00100367 - complaint related to concerns of neglect, care and operation of the home.
- Intake: #00101284, #00099715 - complaints related to an unexpected death of a resident.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A multifaceted complaint was received by the Director. One concern related to the management of a resident's hydration.

A resident's treatment administration record (TAR) directed nursing staff to check the resident's daily fluid intake at a specific frequency; to document a hydration assessment in point click care and if the resident had signs/symptoms of dehydration and/or if fluid intake was less than their requirement to send a referral to the Registered Dietitian (RD).

A hydration assessment was documented by nursing staff as the resident was not meeting their daily fluid requirements for the assessment period. An interview with the RD and a record review failed to identify referrals, in both instances, being sent to the RD. Several days later, the resident was sent to the hospital for assessment and treatment related to the management of the resident's hydration.

Failing to ensure a referral was sent to the RD when the resident's fluid intake was not met delayed the assessment and implementation of interventions further placing the resident at risk of issues related to hydration.

Sources: Progress notes, TARS, RD referrals and interview with RD. [110]

WRITTEN NOTIFICATION: Dietary Services and Hydration

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

Non-compliance with: FLTCA, 2021, s. 15 (1) (b)

Dietary services and hydration

s. 15 (1) Every licensee of a long-term care home shall ensure that there is,

(b) an organized program of hydration for the home to meet the hydration needs of residents.

The licensee failed to ensure an organized program of hydration for the home to meet the hydration needs of residents.

Rationale and Summary

A multifaceted complaint was received by the Director. One of the concerns, that focused on weekends, was related to the home not offering sufficient fluids.

On Sunday, a lunch and dinner meal service were observed. The posted menu did not include planned fluids however, residents were offered water; a choice of juice and some residents were also offered their preference of tea or coffee. Milk or a milk alternative was not offered. The beverages and glass sizes served varied with residents #004 and #005 being served 125 milliliter (mL) glass of water and coffee at dinner with no associated direction in "MealSuite", the resident's dietary profile, not to offer milk or juice. Other residents received a 250ml glass of water and 125ml of juice. At lunch, Personal Support Worker (PSW) #115 who served beverages revealed they normally served water in a large glass and juice in a small one. At dinner PSW #117 confirmed they served one glass water and one glass of juice, confirming resident #004 never asked for milk as the reason why milk was not offered. PSW #117 further shared the size of glasses served depended on the glasses available and milk was not offered unless requested.

During an afternoon snack service residents were offered a choice of juice or water in a 125ml glass or coffee/tea in a mug. Milk or a milk alternative was not offered.

The home's hydration program failed to identify the minimum number of beverages, types and volume to be offered by the menu per day. The Registered Dietitian (RD) and Food Service Manager (FSM) stated 1500mls of fluids are to be offered; 375mls

per meal and 125mls at nourishment mainly as water, juice and coffee or tea and the provision of milk or chocolate milk was provided upon resident request. A document titled "suggested daily beverage provision" provided to Inspector was only a guide, not a policy, according to the FSM. The document revealed meals will provide 1500mls and snacks 750mls of fluids for a total of 2250mls and milk is offered at all meals. The RD confirmed standard fluids, including milk should be part of the planned menu.

According to Dietitian of Canada's Menu planning in Long Term Care document, dated July 2020, "a suggested daily menu target is offering a minimum of 2000ml on the menu". Further, "Including milk or fortified soy beverages on the menu with meals or between meals is important to meeting the Daily Recommended Intake (DRI) targets for calcium and vitamin D. For individuals who do not consume milk, alternative sources of these nutrients are important, some of which can be incorporated into the overall menu and some as individualized plans."

Failing to ensure a minimum offering of fluids at meals and snacks may limit resident access to adequate fluids to promote hydration. Failing to ensure milk and milk alternatives are planned and offered may also limit resident access to meeting the DRI targets for nutrients.

Sources: Observations, Menu, home's policies, document titled "Suggested Daily Beverage Provision", Dietitian of Canada's Menu planning in Long Term Care document, dated July 2020, "Mealsuite" dietary profile and interviews (PSW #115, #117, FSM and RD). [110]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary

The Substitute Decision Maker (SDM) for a resident shared a written complaint emailed to the home with care concerns and an allegation of neglect.

The home's binder for Client Services Response forms along with the Complaint/Concern/Request/Compliment Monthly Log failed to include documentation of the SDM's complaint regarding care and neglect. The Executive Director (ED) indicated the complaint should have been entered into the monthly

log for the documented record and shared that a Critical Incident was reported about the SDM's allegation of neglect.

Failure to document concerns, specifically the nature of the concern, action taken and response to resident's SDM poses the potential for a deterioration in care and service relationships and could negatively impact the resident's quality of life.

Sources: Written complaint. Home's Complaint Binder/ Client Services Response Forms; Complaint/Concern/Request/Compliment Monthly Log, interviews with resident #003's SDM and the ED. [110]

COMPLIANCE ORDER CO #001 Home to be Safe, Secure Environment

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee is ordered to comply with the following:

1) The DOC shall audit weekly for one month all resident common areas where staff are working to ensure personal possessions are not present. Keep a documented record of the audits including the date, individual conducting the audits, results of the audits, and the corrective actions taken.

2) The IPAC Lead shall develop a policy and procedure to guide roles and responsibilities for communicating outbreak status in the home and the associated required direction for where staff are required to store their personal belongings and take meal breaks. Communication responsibilities should designate staff for days the IPAC Lead is off. Provide training on this policy and procedure to all department managers. Keep a documented record of this training including the contents, who provided the training and a list of staff who attended. This record is to be made available to inspectors immediately upon request.
3) Immediately remove the slide bolt lock on the identified room door and install a door handle with key lock should the room require locking.

Grounds
The licensee failed to ensure the home was a safe and secure environment for residents, specifically for a resident who died unexpectedly from a preventable hazard.

Rationale and Summary

A Critical Incident (CI) was received by the Director reporting the unexpected death of a resident from a preventable hazard. The Ministry received a concern from the Coroner's Office identifying the resident's death as preventable and a complaint was also received reporting the mishandling of the critical incident.

Housekeeper #110, heavy duty cleaner #111, PSWs #106, #120 and Registered Nurse (RN) #103 shared that there were times when staff were directed to use a resident area and that items were placed in the area for that purpose.

The heavy duty cleaner #111 confirmed they were asked by RN #103 to place items in the identified resident area for the purposes of staff. A maintenance log included

the cleaner's dated entry around the placement of these items and equipment in resident area. RN #103 confirmed the direction given to the cleaner, and shared the reason was for the purpose of staff.

An interview with housekeeper #110 confirmed they were aware that staff began using the resident area for the known purpose and assumed if items were still in the area, then the circumstances in the home required staff to continue to use the area.

Resources available confirmed that staff were using the identified resident area as well as an identified resident. RPN #104 revealed that the identified resident accessed something unsafe while in the named resident area.

The IPAC lead revealed that staff were not to use the identified resident area in question. On a specific date, after a resident accessed something unsafe in this area, equipment, previously placed for staff use, was removed from the room.

The Executive Director (ED) confirmed that the identified room was a resident area and was not to be used by staff. They were unaware that RN #103 gave direction to staff to use the room and that items were set up for this purpose.

Failure to ensure that resident areas that were converted into temporary staff areas were secured and maintained in a safe state as required contributed to a resident accessing unsafe items and requiring emergency intervention.

Sources: surveillance resources, Cleaning and Repair Checklist Summary-maintenance log, Medical Certificate of death and interviews (Housekeeper #110, heavy duty cleaner #111, PSWs #106 and #120, RPN #104, RN #103, ESM manager, IPAC lead and ED). [110]

COMPLIANCE ORDER CO #002 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee is ordered to comply with the following:

1) A certified Red Cross trainer shall provide training for all nursing staff and others who provide meal and snack service, as to the signs and symptoms of a choking resident and their role in responding to a choking resident. Keep a documented record of the training including the contents, dates of the training, who provided the training and a list of staff who attended. This record is to be made available to inspectors immediately upon request.

2) All registered staff shall be provided with in-person training and demonstration on how to call a CODE BLUE emergency and how to conduct a CODE BLUE with a conscious and unconscious choking resident, including but not limited to residents who are positioned in a chair and in bed. Keep a documented record of this training including the contents, dates of the training, who provided the training and a list of staff who attended. This record is to be made available to inspectors immediately upon request.

3) The licensee will develop a policy and procedure around suctioning based on evidence-base practice and if there are none, current prevailing practices. Provide training on this policy and procedure to all registered staff. Keep a documented record of this training including the contents, dates of the training, who provided the training and a list of staff who attended. A record is to be made available to

inspectors immediately upon request.

4) Education shall be provided to RPN #104 and RN #103 on the home's policy - LTC - Cardiopulmonary Resuscitation (CPR), Abdominal Thrusts #CARE4-010.11, reviewed date March 31, 2023 and "Abdominal/Chest thrusts and the associated " fact sheet. Administer a supervised test to both registered staff post training. Ensure both staff complete testing independently and without aid. Ensure that any staff receiving a final grade of less than 85% on the test is provided with retraining and is retested on the materials. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered. A record is to be made available to inspectors immediately upon request.

Grounds

The Licensee failed to ensure that the home protected a resident from neglect by RPN #104 and RN #103.

Rationale and Summary

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) was received by the Director reporting the unexpected death of a resident related to a preventable hazard. A complaint was also received alleging the inaction of registered staff of the critical incident.

RPN #104 revealed that a resident accessed something unsafe. Resources available and interviews with PSW #107, RPN #104 and RN #103 revealed that the RN and RPN failed to take actions directed by the home's policies and as required by their training. Further, despite the RN directing the RPN to call emergency response services and additional directions as per policy, PSWs #114, #107 and #106 shared the additional directions was not implemented during their shift at the time of the incident.

A former staff, who was aware of the details of the incident confirmed the expectation of the RN.

The Medical Certificate of Death identified the cause of death that warranted specific measures to be taken by staff.

The Executive Director stated the staff used their clinical judgement at the time of the incident.

A resident was neglected when RPN #104 and RN #103 failed to provide the required treatment, care, or assistance by not initiating measures according to the home's policies and training when required. Inaction was also demonstrated when additional direction was not implemented by staff in the home. Further inaction was identified when the Executive Director took no corrective action to address or re-educate registered staff involved in the incident for failing to follow the home's policy when responding to the resident's condition.

Failure to respond and implement additional measures eliminated a resident's access to lifesaving measures.

Sources: surveillance resources, home's policy - LTC - Cardiopulmonary Resuscitation (CPR), Abdominal Thrusts #CARE4-010.11, reviewed date March 31, 2023, "Abdominal/Chest thrusts - Helping a resident who is choking fact sheet, the

Medical Certificate of Death, training certificates for Basic Life Support (BLS) Provider from Heart and Stroke, Resuscitation Support Centre Heart & Stroke BLS Provider Training documents and interviews (RPN #104, RN #103, PSW #107, former DOC, ED) (. [110]

This order must be complied with by February 7, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued to s. 19.(1) on July 8, 2021 during a CI Inspection #2021_823653_0016.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after

service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.