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

Public Report

Report Issue Date: March 26, 2025
Inspection Number: 2025-1378-0001
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18-21, 24-26, 2025

The following intake(s) were inspected in the Critical Incident (CI) inspection:

- One intake was related to a fall with injury.
- One intake was related to improper care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

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. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure Additional Requirement 9.1 (e) for Additional Precautions under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022, revised September 2023), issued by the Director was complied with. Specifically, the licensee has failed to ensure that point-of-care signage indicating that enhanced IPAC control measures were in place for a resident was posted.

A resident's room had a caddy with Personal Protective Equipment (PPE) at the door. There was no signage on the door or in the area to indicate that additional precautions were in place or what PPE was required. The next day point-of-care signage was observed outside the resident's room indicating additional precautions were in place.

The IPAC Lead confirmed that the resident was supposed to be on additional precautions for direct care related to potential infection and that signage was required.

Sources: Observations, interview with the IPAC Lead.

Date Remedy Implemented: March 19, 2025

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the home's falls prevention and management program which provided for strategies to reduce or mitigate falls was followed for a resident.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's fall policy indicated that prevention strategies to reduce or mitigate falls are implemented to meet the needs of each resident. Universal fall prevention strategies included resident using proper footwear.

A fall incident was report for a resident. A Registered Practical Nurse (RPN) assessed the resident post fall and documented a specific item on the resident was inappropriate. The RPN indicated that the improper item was a contributing factor to the fall.

At the time of inspection, the resident's care plan indicated they were at risk for falls and had a specific fall prevention intervention in place. During observation of the resident on the home area, they were found without the specified intervention.

The RPN and the Associate Director of Care (ADOC) acknowledged that staff are expected to ensure that the resident always has this intervention in place as part of their fall prevention strategies.

Sources: A resident's clinical record, Critical Incident Report, policy Fall Prevention and Injury Reduction Program, observations, interview with RPN and the ADOC.

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