



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2015	2015_417178_0014	023594-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 9, 10, 14, 2015.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered staff, Assistant Director of Care (ADOC), Director of Care (DOC), Physiotherapist, Executive Director.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

2 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>Legendé</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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**



Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is reviewed and revised when care set out in the plan has not been effective.

Review of resident #01's progress notes confirmed that the resident fell three times within an identified eight day period. At the time of the third fall, the resident was found on the floor in his/her room. The resident experienced pain, and was transferred to hospital for assessment, where the resident was found to have a mild fracture, likely from an old injury. Interviews with staff #100, the home's ADOC, and the DOC confirmed these facts.

Review of the resident #01's plan of care confirmed that the resident's plan of care to prevent falls remained unchanged after the resident's first two falls. After each fall the resident was reassessed by the Physiotherapist and recommendations were made, including a bed pad alarm and an assisted toileting routine. Review of the resident's plan of care and interviews with the home's DOC and ADOC confirmed that resident #01's plan of care was not revised to include the use of a bed pad alarm and an assisted toileting routine.

Interviews with PSWs reveal inconsistent toileting of the resident, and no use of a specific toileting routine to prevent falls in this resident.

A review of the resident #01's progress notes gives no indication that a bed alarm was in use before the resident's third fall. Interviews with PSWs, the home's ADOC and the DOC do not confirm use of a bed alarm prior to the third fall. Review of the resident's progress notes and interviews with front line staff and the DOC confirm that after the resident's third fall, a clip on alarm was put into use when the resident was in bed or in the wheelchair. [s. 6. (10) (c)]



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 to ensure that the plan of care is reviewed and revised when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Review of the home's Daily Schedules revealed that during the night shifts on September 1, 10, 11, 12, 14, and 15, 2015, there was no registered nurse who is both an employee of the licensee and a member of the regular nursing staff on duty in the home. A registered nurse from a staffing agency was on duty during these shifts.

The ED confirmed that on the above night shifts, a registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was not on duty. [s. 8. (3)]



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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 to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

Issued on this 21st day of September, 2015

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

Original report signed by the inspector.