Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 12, 2019	2019_749653_0018	012782-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 10, 11, 12, 15, and 16, 2019.

Complaint Log #012782-19 related to continence care and bowel management, nutrition and hydration, skin and wound care, falls prevention and management, and plan of care concerning resident #001 had been inspected.

During the course of the inspection, the inspector reviewed clinical health records, staffing schedule, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Senior Investigator of the Patient Ombudsman Office, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

A Voluntary Plan of Correction related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent CIS inspection report #2019_749653_0019 (Log #: 021808-17) will be issued in this complaint inspection report #2019_749653_0018 (Log #: 012782-19).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a complaint letter regarding care concerns related to resident #001. The complainant indicated the Personal Support Workers (PSWs) in the home did not provide the required assistance for an identified Activity of Daily Living (ADL).

A review of resident #001's written plan of care indicated they required assistance for the identified ADL.

Separate interviews with PSW #101 and Registered Practical Nurse (RPN) #103 indicated different answers related to resident #001's required assistance for the identified ADL.

During separate interviews, RPN #103 and the Associate Director of Care (ADOC) reviewed resident #001's written plan of care and acknowledged it did not provide clear directions in terms of the frequency of the provision of assistance for the ADL. RPN #103 further indicated the written plan of care should have specified when PSWs would provide the assistance to the resident. The ADOC indicated around that time the home did not have a continence lead, and they had identified the issue regarding unclear directions on the required assistance for the ADL, in the written plan of care. [s. 6. (1) (c)]

2. The licensee had failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The MLTC received a complaint letter regarding care concerns related to resident #001. The complainant indicated on an identified date and time, the Substitute Decision-Maker (SDM) received a call from a staff member who informed them of an identified outbreak in the home and the resident would be given an identified medication. The SDM indicated the resident should not be given the medication, and requested for the attending physician to order an alternative. On an identified date, the SDM received an invoice from pharmacy indicating medications were prescribed and given to resident #001 against the SDM's instructions to the home.

A review of resident #001's physician's order review signed by the attending physician indicated a standing order for the identified medication in case of an identified outbreak.

A review of resident #001's progress notes indicated the staff educator called and left a message to the SDM to contact nurse in regards to giving consent for the medication. Further review of the resident's progress notes indicated on two different dates and times, two different RPNs documented under the electronic Medication Administration Record (eMAR) note for the identified medication, that the SDM refused consent.

A review of resident #001's eMAR, indicated the identified medication was signed off as given on three different occasions.

An interview with RPN #103 indicated they were aware the SDM did not want the identified medication to be given to resident #001. The RPN reviewed the resident's eMAR and acknowledged they had signed off the identified medication was administered to the resident. RPN #103 indicated if the SDM had refused, the attending physician

should have been notified for the identified medication to be discontinued.

During an interview, RPN #102 reviewed the resident's eMAR and acknowledged they had signed off the identified medication was administered to the resident. The RPN indicated if the SDM refused, the identified medication should have been taken out of the medication cart, and they should have called the attending physician to discontinue the medication.

During an interview, the ADOC reviewed resident #001's physician's order review, eMAR, and progress notes, and acknowledged the staff and others involved in the different aspects of care of the resident did not collaborate with each other in the development and implementation of the plan of care. The ADOC further indicated if the SDM refused, the nurses would make a note, notify the attending physician, and update the pharmacy. [s. 6. (4) (b)]

3. The licensee had failed to ensure that care was provided to resident #001 as specified in the plan.

The MLTC received a complaint letter regarding care concerns related to resident #001. The complainant indicated on an identified date, resident #001 had an identified medical procedure scheduled, and the registered staff were given a booklet with instructions to be followed the day before the procedure. On the morning of the identified day, resident #001's family arrived in the home to pick them up and learned PSW #101 did not follow the instructions identified in the booklet. As a result, the hospital advised the resident's medical procedure would be performed later in the day instead of the original schedule, and resident #001 had to spend time waiting at the hospital.

A review of resident #001's identified guide for the medical procedure, indicated identified instructions to be followed the day before the medical procedure.

A review of resident #001's Point of Care (POC) documentation for an identified ADL on the identified shift, and an interview with PSW #101 indicated the PSW did not follow the instructions provided in the booklet. PSW #101 stated they were made aware of the instructions but had totally forgotten about it.

During an interview, the ADOC acknowledged care was not provided to resident #001 as specified in the plan when PSW #101 did not follow the instructions identified in the booklet prior to resident #001's scheduled medical procedure. [s. 6. (7)]

4. The MLTC received a complaint letter regarding care concerns related to resident #001. The complainant indicated during an identified time period, the SDM was notified of resident #001's dietary restriction as ordered by the physician.

A review of resident #001's physician digiorder form indicated the attending physician ordered a dietary intervention.

A review of resident #001's POC look back report for daily intake for an identified period of 29 days, indicated their daily intake was above the prescribed intervention.

An interview with PSW #101 indicated either resident #001's written plan of care directed them or the registered staff specifically verbalized to them that there was an ordered intervention to resident #001's daily intake at the time.

An interview with RPN #102 indicated they remember there was an ordered intervention. The RPN reviewed the resident's physician's digiorder form, and POC daily intake documentation for the identified period, and acknowledged care was not provided to the resident as specified in the plan in terms of the identified intervention.

An interview with RPN #103 indicated they could not recall anything about resident #001's identified intervention. The RPN reviewed the resident's physician's digiorder form and the resident's POC daily intake documentation for the identified period, and acknowledged care was not provided to the resident as specified in the plan in terms of the identified intervention.

During an interview, the Registered Dietitian (RD) reviewed the resident's physician's digiorder form and the resident's POC daily intake documentation for the identified period, and acknowledged the intervention was not followed by staff, and care was not provided to the resident as specified in the plan. [s. 6. (7)]

5. As a result of non-compliance identified related to resident #001's care not provided as specified in the plan in regards to an identified nutritional intervention, the sample size was expanded to two additional residents including resident #002.

A review of resident #002's written plan of care indicated they had identified interventions as per the doctor's order.

A review of the dietary binder located in resident #002's home area servery indicated their nutritional plan.

A review of resident #002's POC look back report for daily intake for an identified period of 27 days, indicated their daily intake was above the prescribed intervention.

During separate interviews, RPNs #102, #103, and #104 acknowledged resident #002 was on an identified intervention. During an interview, the RD reviewed resident #002's POC look back report for daily intake for the identified period, and acknowledged the intervention was not followed by staff, and care was not provided to the resident as specified in the plan. [s. 6. (7)]

6. As a result of non-compliance identified related to resident #001's care not provided as specified in the plan in regards to an identified nutritional intervention, the sample size was expanded to two additional residents including resident #003.

A review of resident #003's written plan of care indicated they had an identified dietary intervention.

A review of the dietary binder located in resident #003's home area servery indicated their nutritional plan.

A review of resident #003's POC look back report for daily intake for an identified period of 19 days, indicated their intake was above the prescribed intervention.

During an interview, the RD reviewed resident #003's POC look back report for daily intake for the identified period, and acknowledged the intervention was not followed by staff, and care was not provided to the resident as specified in the plan. [s. 6. (7)]

7. The following evidence was identified under Critical Incident System (CIS) inspection report #2019_749653_0019 (Log #: 021808-17):

The licensee had failed to ensure that care was provided to resident #002 as specified in the plan.

The home called the MLTC after hours infoline on an identified date and time, and subsequently submitted a Critical Incident Report (CIR) related to improper/ incompetent treatment of a resident that resulted in risk of harm to resident #002. The CIR indicated

on an identified date, an alteration in skin integrity from unknown cause was noted on resident #002, and there was no reported incident of a fall.

A review of resident #002's written plan of care including the Kardex and POC task indicated the frequency of safety checks as per the SDM's request.

A review of resident #002's progress notes indicated on an identified date, the resident was found with an alteration in skin integrity. The registered staff initiated an identified assessment as the resident could not remember how they sustained the injuries. Further review of progress notes indicated on an identified date, the previous DOC had a conversation with resident #002's SDM and assured them a thorough investigation of the alteration in skin integrity would be completed. A review of the Risk Management Module (RMM) indicated the previous DOC reviewed the home's video surveillance and found that during an identified shift, PSW #100 checked the resident twice during the shift.

An interview with PSW #100 acknowledged they worked during the identified shift, and was assigned to resident #002's care. However, they could not entirely recall the incident. The PSW indicated they remember the previous DOC had spoken to them and they were suspended for a time because the previous DOC determined they did not go in the resident's room and check on them as per the frequency of checks identified in the Kardex and POC task. PSW #100 acknowledged they did not monitor resident #002 as required by their plan of care. The PSW further indicated they did not recall any incident that night that may have caused resident #002's injuries.

An interview with the ADOC acknowledged that in above mentioned incident, care was not provided to resident #002 as specified in the plan, when the PSW did not check on them as required by the plan of care. [s. 6. (7)]

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:
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
-the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other;
-that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure there was an individualized menu developed for resident #001 if their needs could not be met through the home's menu cycle.

A review of resident #001's physician digiorder form indicated the attending physician ordered a nutritional intervention.

A review of resident #001's progress notes indicated the RD documented they received recommendation from the attending physician. The RD recommended an intervention for medical reasons. No dietary change, the RD left a note in doctor's book to reassess the intervention, attending physician to visit the following day.

A review of resident #001's written plan of care indicated the RD added the dietary intervention 21 days after they received the recommendation from the attending physician.

A review of resident #001's POC look back report for daily intake for an identified period of 29 days, indicated their daily intake was above the prescribed intervention.

During an interview, the Registered Dietitian (RD) reviewed the resident's physician's digiorder form, progress notes, and written plan of care with Inspector #653. The RD acknowledged that an individualized menu was not developed for resident #001 when their needs could not be met through the home's menu cycle during the identified period. [s. 71. (5)]

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 an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

The MLTC received a complaint letter regarding care concerns related to resident #001.

A review of resident #001's Point Click Care (PCC) census records indicated they were discharged from the home a year and five months prior to the inspection.

During the course of the inspection, Inspector #653 reviewed resident #001's clinical health records from 2015, 2016, 2017, and 2018, and noted the original physician's digiorder forms for September, October 2015, and May, June 2016, were missing. The inspector provided the home an opportunity to search for the above-mentioned records, however, the records were not found.

During an interview, the ED acknowledged the home was not in compliance with s. 233 (1) of the O. Reg. 79/10, as the above-mentioned original clinical health records could not be found. [s. 233. (1)]

Issued on this 28th day of August, 2019

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

Original report signed by the inspector.