Ontario

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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 17, 2017	2017_505103_0037	015839-17, 016014-17	Complaint

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street Stouffville ON L4A 4J3

Long-Term Care Home/Foyer de soins de longue durée

FRIENDLY MANOR NURSING HOME
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

DARLENE MURPHY (103)

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): August 16-17, 2017

**Log #015839-17 (Complaint related to alleged staff to resident verbal abuse),
Log #016014-17 (Critical incident reporting alleged staff to resident verbal abuse).**

During the course of the inspection, the inspector(s) spoke with a resident, a PSW, a Registered Nurse, the RAI coordinator, an Activation aide, and the Administrator.

During the course of the inspection, the inspector reviewed the resident health care record including progress notes and the resident plan of care, the home's investigation notes related to the alleged incident of resident abuse, the home's abuse policy and the home's education records related to the staff alleged to have been involved in the incident.

**The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation**

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

- **1 WN(s)**
- **0 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	Legendé 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 O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Resident #001 was admitted to the home on an identified date and had identified diagnoses.

On an identified date on or about 0300 hour, PSWs #102 and #104 entered resident #001's room in response to the roommate's bed alarm sounding. PSW #102 was interviewed and indicated resident #001's lights were on when they entered the room. The PSWs felt this was contributing to the roommate's attempts to climb out of bed and turned off resident #001's light. According to PSW #102, resident #001 woke up when the light was turned off and stated they could not sleep with the light off.

Resident #001 was interviewed and stated it has always been their routine to sleep with a light on and this routine began as a result of previous work habits. The resident stated he/she had been sleeping with their over bed light on since admission to the home and without the light he/she was unable to sleep. The resident stated that when he/she insisted on the light being left on, the PSW's told the resident to turn it off or they would.

Staff members were interviewed and confirmed it was resident #001's usual bedtime routine to sleep with the light on.

The DOC was interviewed and stated the night staff were aware of resident #001's routine of sleeping with the lights on, but had never brought this forward to be included in the resident's plan of care. The DOC indicated the incident was investigated and staff were reprimanded for their actions. The DOC also indicated a smaller bedside lamp is now being used by resident #001 and the resident's plan of care has been updated to reflect the use of the night light.

The licensee failed to ensure resident #001's bedtime routine was supported and individualized to promote sleep. [s. 41.]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.