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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St., 4th Floor
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347, rue Preston, 4iém étage
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☐ **Licensee Copy/Copie du Titulaire** X **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 10 and 11, 2011	2011_117_2640_10Jan110847	Complaint Log # O-000046

Licensee/Titulaire

Sherwood Park Manor
1814 County Road 2 East
Brockville, ON
K6V 5T1
Fax: (613)342-3767

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

Sherwood Park Manor
1814 County Road 2 East
Brockville, ON
K6V 5T1
Fax: (613)342-3767

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

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the use of a restraint on a resident.

During the course of the inspection, the inspector spoke with the home's Administrator, the home's Assistant Director of Care; an East Wing day shift unit Registered Nurse, to two East Wing day shift Registered Practical Nurses, to three East Wing unit Personal Support Workers, to two residents as well as to family members of one of the residents.

During the course of the inspection, the inspector reviewed two residents health care records, reviewed the East Wing unit's 24-hour nursing report and examined the two rooms

The following Inspection Protocols were used during this inspection:

- Minimizing Restraint
- Responsive Behaviours
- Dignity, Choice and Privacy
- Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 CO: CO # 001, #002 & #003

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

1. The home's administration failed to report to the Director the incident of November 5, 2010 where a resident received improper care and treatment by being restrained to his/her bed by a flannel blanket during the night of November 5 2010.

2. The home's administration failed to report to the Director the incident of November 5, 2010 where a resident was neglected when he/she was told not to ring his/her call bell and that he/she would not be toileted during the night of November 5 2010 by an unidentified night time staff member. The resident reports that he/she was not toileted and soiled his/herself in his/her incontinence brief during the night of November 5 2010. The home's day time Registered Nurse reported that the resident was visibly upset when he/she reported not being toileted and having to soil his/herself during the night of November 5 2010.

Compliance Order #001 was faxed to the licensee – See Order Report

Inspector ID #:	# 117

WN #2: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirement provided for under this Act.

Findings:

1. On November 5, 2010, at approximately 07:00am, a resident was found by two Personal Support Workers to be restrained in bed with a flannel blanket, a prohibitive device as identified under O.Reg 79/10 section 112 (7). The flannel blanket was applied around his/her torso, with both ends of the blanket tightly tucked between the mattress and bed frame.

2. The two Personal Support Workers who found the resident restrained by the flannel blanket state that the resident could not get out of bed by his/herself. They also state that the resident was visibly upset.

3. On November 5, 2010 a resident reported having been told by an unidentified night time staff member not to ring his/her call bell and that he/she would not be toileted during the night. The resident reports that he/she was not toileted during that night and soiled him/herself in his/her incontinence brief.

4. The home's day time Registered Nurse reported that the resident was visibly upset when he/she reported not being toileted and having to soil him/herself during the night of November 5 2010.

Compliance Order #002 was faxed to the licensee- See Order Report

Inspector ID #:	# 117

WN #3: The Licensee has failed to comply with the. O. Reg. 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings:

1. On November 5, 2010, at approximately 07:00am, a resident was found by two Personal Support Workers to be restrained in bed with a flannel blanket, a prohibitive device as identified under O.Reg 79/10 section 112 (7). The flannel blanket was applied around his/her torso, with both ends of the blanket tightly tucked between the mattress and bed frame.

Compliance Order #003 was faxed to the licensee - See Order Report

Inspector ID #:	#117

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection). January 24, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Lyne Duchesne	**Inspector ID #**	117
Log #:	O-000046		
Inspection Report #:	2011_117_2640_10Jan110847		
Type of Inspection:	Complaint		
Date of Inspection:	January 10 and 11, 2011		
Licensee:	Sherwood Park Manor 1814 County Road 2 East Brockville, ON K6V 5T1 Fax: (613)342-3767		
LTC Home:	Sherwood Park Manor 1814 County Road 2 East Brockville, ON K6V 5T1 Fax: (613)342-3767		
Name of Administrator:	Shawn Souder		

To, Sherwood Park Manor you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with : LTCHA 2007, S.O. 2007, c.8, s. 24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance when the licensee has reasonable grounds to suspect that any concerns of improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident occurred or may occur, the licensee shall immediately report the suspicion and the information upon which it is based to the Director.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by January 31 2011 via fax # (613) 569-9670

Grounds:

1. The home's administration failed to report to the Director the incident of November 5, 2010 where a resident received improper care and treatment by being restrained to his/her bed by a flannel blanket during the night of November 5 2010.

2. The home's administration failed to report to the Director the incident of November 5, 2010 where a resident was neglected when he/she was told not to ring his/her call bell and that he/she would not be toileted during the night of November 5 2010 by a unidentified night time staff member. The resident reports that he/she was not toileted and soiled him/herself in his/her incontinence brief during the night of November 5 2010. The home's day time Registered Nurse reported that the resident was visibly upset when he/she reported not being toileted and having to soil him/herself during the night of November 5 2010.

This order must be complied with by:	January 31 2011		
Order #:	002	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with : LTCHA 2007, S.O. 2007, c.8, s.3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirement provided for under this Act.

Order: The licensee shall prepare, submit, and implement a plan for achieving compliance to meet the requirement that every resident shall be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity, ensuring that every resident shall be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his of her needs as well as ensuring that residents not be restrained, except in the limited circumstances provided for under this Act.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by January 31 2011 via fax # (613) 569-9670

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Grounds:

1. On November 5, 2010, at approximately 07:00am, a resident was found by two Personal Support Workers to be restrained in bed with a flannel blanket, a prohibitive device as identified under O.Reg 79/10 section 112 (7). The flannel blanket was applied around his/her torso, with both ends of the blanket tightly tucked between the mattress and bed frame.

2. The two Personal Support Workers who found a resident restrained by the flannel blanket state that the resident could not get out of bed by his/ herself. They also state that the resident was visibly upset.

3. On November 5, 2010 a resident reported having been told by an unidentified night time staff member not to ring his/her call bell and that he/she would not be toileted during the night. The resident reports that he/she was not toileted during that night and soiled him/herself in his/her incontinence brief.

4. The home's day time Registered Nurse reported that the resident was visibly upset when he/she reported not being toileted and having to soil him/herself during the night of November 5 2010.

This order must be complied with by:	January 31 2011		
Order #:	003	**Order Type:**	Compliance Order, Section 153 (1) (a)

Pursuant to: The Licensee has failed to comply with O. Reg 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Order:

The licensee is ordered to stop using prohibited devices to restrain residents as identified in O.Reg 79/10, section 112.

Grounds:

1. On November 5, 2010, at approximately 07:00am, a resident was found by two Personal Support Workers to be restrained in bed with a flannel blanket. The flannel blanket was applied around his/her torso, with both ends of the blanket tightly tucked between the mattress and bed frame.

This order must be complied with by:	Immediate

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order 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 or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board **and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
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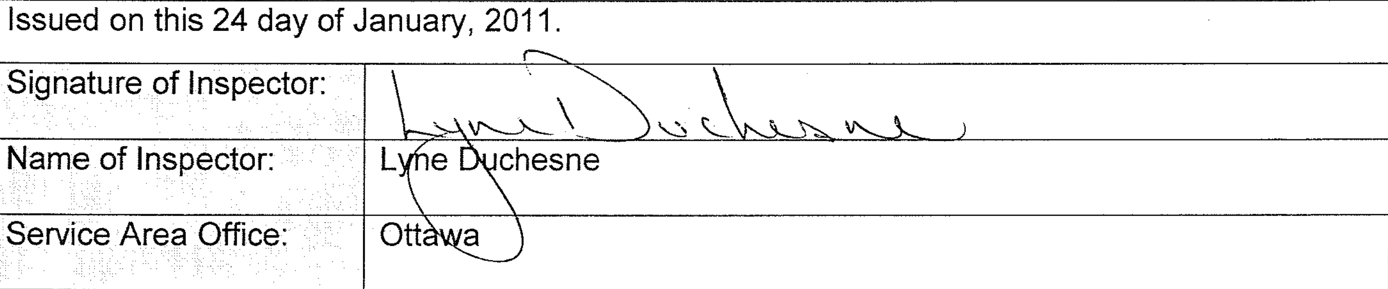
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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



Issued on this 24 day of January, 2011.	
Signature of Inspector:	
Name of Inspector:	Lyne Duchesne
Service Area Office:	Ottawa