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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 4, 2019	2019_702197_0016	001052-19, 001103-19	Follow up

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 17-20, 25, 2019

The following logs were completed as part of this report:
001052-19 - a follow-up inspection to ensure that residents' plans of care were being provided as specified in the plan
001103-19 - a follow-up inspection to ensure that the direction in residents' plans of care is clear to those who provide care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Physiotherapist, Registered Nurses, Personal Support Workers and residents.

The inspector also reviewed resident health care records, relevant policies and procedures, staff training records and education material and observed resident care.

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.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2018_765541_0017	197
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_702197_0026	197

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The following findings are further evidence to support CO #001 issued on June 13, 2019 during follow-up inspection 2019_625133_0012. The incidents below occurred before the compliance due date of September 13, 2019.

The licensee has failed to ensure that where bed rails were used, the residents were assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On March 27, 2019, the Ministry of Health and Long-Term Care issued a memo to the Long-Term Care sector on the proper use of bed rails.

The document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings (FDA, 2003)" was identified as the prevailing practice document that is to be used to guide the assessment of residents. Related to entrapment events, direction is given to re-assess the resident's needs and re-evaluate the equipment if an episode of entrapment occurs, with or without serious injury. This is to be done immediately because fatal "repeat" events can occur within minutes of the first episode.

On a specified date, a progress note was made indicating that resident #004 was found with their buttocks/legs on the floor in a sitting position, leaning to the left side and their left arm and head was between the mattress and quarter railing. The progress note also indicated that the resident's torso was pressed up against the "bed arm for the mattress attached to the railing". The resident was assessed for injuries and assisted back to bed.

Two days later, resident #004 was found sitting on the floor with their right arm straight, caught between the bed rail and the mattress. The resident was assessed and then assisted back to bed.

The day after the second incident, a Registered Nurse emailed the Assistant Director of Care regarding bed safety and repetitive falls out of bed for resident #004. Later that day, the ADOC noted that resident #004's bed rails had been removed since the home felt the resident was at greater risk with the bed rails than without.

A reassessment of resident #004's use of bed rails did not occur immediately following the first entrapment event. [s. 15. (1)]

2. On a specified date, resident #002 was admitted to the home. An admission progress note indicated that bed rails were not wanted at that time.

Review of the resident's current care plan indicated that no bed rails were used for resident #002.

Resident #002's room was observed on during the inspection period and it was noted that two bed rails were in place on the resident's bed. Resident #002 indicated at that time that they use the bed rails to help them get out of bed.

A PSW was interviewed and indicated they were not sure why the bed rails were put into place for resident #002.

The ADOC was also unable to find out when and why resident #002 had two bed rails put up on their bed.

Upon review of the resident's paper and electronic health care record, there was no evidence that resident #002 had been assessed for the use of bed rails, to minimize risk to the resident. [s. 15. (1)]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.