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 29, 2019	2019_664602_0038	014263-19, 015511-19, 015834-19	Critical Incident System

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 21, 22, 23, 26 & 27, 2019

Log# 015834-19/CIS# 2640-000010-19 - regarding a fall with injury, transfer to hospital and unexpected death.
Log# 015511-19/CIS# 2640-000009-19 - regarding a fall with injury and transfer to hospital.
Log# 014263-19/CIS# 2640-000008-19 - regarding a fall with injury and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Physiotherapist, a Physiotherapy assistant and the Resident and Family Services manager.

As part of the inspection, a review of electronic health records was completed. Multiple interview(s) and observations of resident care and services were also conducted. In addition, relevant policies and procedures and hospital documentation were reviewed.

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)**
- **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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care.

On a specified date resident #001 had an unwitnessed fall. The resident was immediately assessed and superficial injury(ies) were noted. On the following day, resident #001 was found to have possible significant injury(ies) and was sent to hospital for further assessment. The resident returned to the home that same day with significant injury(ies).

A review of resident #001's plan of care, updated on a specified date, indicated that a specified program continued. The resident returned from hospital with significant injury (ies), as a result, they could not participate in the specified program. Resident #001's written plan of care did not set out clear direction to staff. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected death.

On a specified date, resident #003 fell while ambulating with their walker inside the home. The resident was transferred to hospital for assessment of a possible significant injury.

A review of resident #003's progress notes indicated the home was contacted on a specified date to advise that the resident had passed away, in hospital.

A critical incident report (CIR) indicating resident #003 had been transferred to hospital following a fall and "passed away" was sent to the Ministry of Long Term Care (MLTC) on a specified date following the fall, and subsequent to their notice of the resident's unexpected death. Further details regarding resident #003's death were requested by the MLTC; the amended CIR outlined that "due to complications from the fall [the] resident passed away in hospital ... coroner will be investigating".

The licensee did not inform the Director immediately as to resident #003's unexpected death. [s. 107. (1) 2.]

Issued on this 29th day of August, 2019

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

Original report signed by the inspector.