Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 21, 22, 27, 28, 2011	2011_034117_0025	Critical Incident

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), several Registered Nurses, several Registered Practical Nurses, to several Personal Support Workers (PSW), to resident family members and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of three identified residents; observed resident care, examined mechanical ceiling lifts and hammock transfer slings; examined bed rails and commodes.

It is noted that three critical incident inspections log # O-000255-11, log # O-001305-11 log # O-001563-11 were conducted during this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Minimizing of Restraining

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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. An identified resident has some cognitive impairment. The resident's plan of care identifies that the resident requires two person assistance for positionning on the commode and that the resident is not to be left unattended when being toileted on the commode.

- On January 25, 2011, the identified resident was positionned on the commode by two PSWs and was left unattended. When the PSWs returned to the room, the resident was found on the floor, beside the commode. The resident had sustained an injury with a pin point laceration.

- The home's DOC confirms that two PSW admitted to leaving the resident unattended on the commode when they knew that the resident's plan of care identified that the resident cannot be left unattended during toileting. [log # O-00255-11]

2. An identified resident has some cognitive impairment and is independently mobile with the aid of a walker. The plan of care identifies that the resident is to have only one bed rail up when in bed.

- On July 15, 2011, the identified resident was found on the floor of his/her room, between the foot of the bed and the window. The resident was wearing nightclothes and slippers. Both bed rails were noted to be up when the resident was found. The resident sustained a fractured wrist. [log # O-001563-11]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. An identified resident has some cognitive impairment and is independently mobile with the aid of a walker. The plan of care identifies that the resident is to have only one bed rail up when in bed.

- On July 15, 2011, the identified resident was found on the floor of his/her room, between the foot of the bed and the window. The resident was wearing nightclothes and slippers. Both bed rails were noted to be up when the resident was found. The resident sustained a fractured wrist.

- There was no order or directives by a physician or a nurse in an extended class for the use of two bed rails, a restraint, at the time of the resident's fall and injury. [log # O-001563-11] [s.110 (2) (1)]

Issued on this 28th day of September, 2011

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

Lynn Duchesne