Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date October 21, 2022
Inspection Number 2022_1148_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Sherwood Park Manor

Long-Term Care Home and City
Sherwood Park Manor, Brockville

Lead Inspector
Amber Lam #541

Additional Inspector(s)
Ashley Bernard-Demers #740787
Anna Earle #740789

Inspector Digital Signature
Amber Lam
Digitally signed by Amber Lam
Date: 2022.11.23 09:52:48 -05'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 23-26, 29 and September 1, 2022.

The following intake(s) were inspected:
A follow-up related to inspection 2022_1148_0002, CO#001 FLTCHA s.6(1)c
A follow-up related to inspection 2022_1148_0002, CO#002, O.Reg 246/22 s.80(2)
One complaint related to staffing, resident care and environmental concerns
Three Critical Incidents related to a fall with injury
One Critical Incident related to a change in condition with transfer to hospital
One Critical Incident related to a medication error

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 80(2)	2022_1148_0002	002	#541

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference	Inspection #	Order #	Inspector (ID) who inspected the order

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FLTCA, 2021	s. 6(1)c	2022_1148_0002	001	#541

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6(10)b

During the inspection, it was noted that a resident's plan of care stated they required assistance of two staff members to perform a specific activity of daily living (ADL). According to two Personal Support Workers (PSWs) and the Director of Care (DOC), the resident had not been able to complete that specific ADL for five months prior to the inspection date.

Prior to the end of the inspection, the licensee updated the resident's plan of care to reflect the ADL is no longer performed.

Sources: Interviews with two PSWs and DOC, plan of care and Kardex for the resident.

Date Remedy Implemented: September 1, 2022

[541]

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that two staff members assisted resident #011 with bathing.

Rationale and Summary

During the inspection it was noted a PSW had just completed bathing for a resident. During a conversation with the PSW, it was noted that the resident was bathed by one PSW and a second PSW assisted with the transfers.

The PSW who bathed the resident specified that the resident requires the assistance of two staff for bathing. It was reported by the PSW that this occurred as there were two staff members working on the unit that shift, and thus they were short-staffed as the compliment is three PSW staff members.

A Registered Nurse (RN) stated that the resident requires a minimum of two staff members to complete bathing related to physical limitations. A review of the resident's care plan in place at the time of observation, confirmed they are totally dependent regarding bathing and required the assistance of two people related to physical limitations.

There is potential for injury to the resident if two staff members are not present during bathing related to their physical care needs.

Sources: Review of the resident's healthcare record (diagnoses), and interviews with a PSW and other staff.

[740787]

WRITTEN NOTIFICATION NURSING AND PERSONAL SUPPORT SERVICES

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that two residents were bathed twice per week.

Rationale and Summary

There was no documentation of a bath being provided to two residents during the day shift on a noted date. Both residents' bath days included the date documentation was missing. A record review indicated that the residents did not receive their scheduled baths on the noted date.

A PSW confirmed that a bath was not provided to the residents on the noted date.

The Assistance Director of Care (ADOC) identified that the expectation for a missed bath is to defer to the next shift, or to provide a bed bath if unable to provide a tub bath or shower.

Missed bathing opportunities have the potential to impact the overall well being of the two residents.

Sources: Review of the Follow-Up Question Report for Bathing for the residents, review of the Nursing Department Bath List, and interviews with a PSW and other staff.

[740787]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 23(2)a*

The licensee failed to ensure that the Infection Prevention and Control program provides evidence based policies and procedures.

Rationale and Summary
During the dining observation it was noted that there was a cart at the entry to each dining room with an alcohol-based hand sanitizer as well as baby wipes.

The Infection Prevention and Control (IPAC) lead and the DOC stated the home uses baby wipes to clean residents hands prior to entering the dining room.

The licensee's handwashing policy was reviewed. In regard to resident hand hygiene, the policy states: "SPM has adopted the use of hand wipes for residents who are unable to use alcohol based hand rub (ABHR) and soap and water is not easily available, such as on entry to dining room."

PIDACs "Best Practices for Hand Hygiene in All Health Care Settings" dated 2014 is considered an evidence based document. On page 19 it states: "ABHR is the first choice for hand hygiene when hands are not visibly soiled." It further states "Wash hands with soap and water if there is visible soiling with dirt, blood, body fluids or other body substances. If hands are visibly soiled and running water is not available, use moistened towelettes to remove the visible soil, followed by alcohol-based hand rub. Hand hygiene is to be performed using alcohol-based hand rub or soap and water."

Baby wipes do not contain alcohol and therefore the licensee's IPAC program's handwashing policy is not based on evidence-based practices.

Sources: Handwashing policy dated May 2022, dining observations throughout inspection, interviews with the IPAC lead and DOC.

[541]

WRITTEN NOTIFICATION REQUIRED PROGRAMS

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure the completion of the Post Fall Screening Tool after a resident's fall.

Rationale and Summary

A resident fell and a Post Fall Screening Tool was not completed. It was confirmed by the ADOC that the expectation is the Post Fall Screening Tool be completed for each fall, by the person who found the resident at the time of the fall. The Fall Prevention Program Policy (Revised Date: Feb 9, 2012) indicated that the responsibility of the registered nursing staff is to review the completed Post Fall Screening Tool for potential fall prevention interventions and modify the plan of care if required.

The impact and risk to the resident of not having the Post Fall Screening Tool completed after their fall, is the potential to not have contributing factors identified and subsequently to not have their plan of care modified accordingly.

Sources: Post fall paper documentation package for a resident's fall, the Fall Prevention Program Policy (Revised Date: Feb 9, 2012) and interviews with the ADOC and other staff.

[740787]

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 140 (2)

The licensee has failed to ensure that drugs/medication were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was ordered to receive a specific amount of a specific medication at bedtime. On One evening the resident was administered the specific amount of a different medication at bedtime in error which resulted in the resident transferring to the hospital for assessment and monitoring.

The ADOC and the RN acknowledged that the wrong medication was administered to the resident.

There is an increased risk of a medical event if the resident is not given the correct medication to control their specific diagnosis.

Sources:
Critical Incident System (CIS) report #2640-000017-22, the resident's progress notes, plan of care, eMAR and interviews with the ADOC, and an RN.

[740789]

COMPLIANCE ORDER [CO #001] SKIN AND WOUND

NC#007 Compliance Order Pursuant to FLCTA, 2021, s. 154(1)2
Non-compliance with: O. Reg. 246/22 *s. 55(2)b(i)*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 ***s. 55(2)b(i)***

The Licensee shall:

1. Use a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
2. Include, at minimum, a section in the assessment instrument for wound measurement and staging.
3. Provide education to registered staff on the use of the skin and wound assessment instrument.
4. Document the date(s) of the education as well as who provided and attended.
5. Update the licensee's skin and wound policies to include actions taken in steps #1 and #2.
6. Document who completed each step and the date it was completed.

Grounds

The licensee has failed to ensure residents #006 and #008 who exhibited altered skin integrity, received an assessment using a clinically appropriate tool, specifically designed for skin and wound assessment.

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Rationale and Summary

A resident's progress notes were reviewed and they were identified as having impaired skin integrity on a date in early 2022.

Another resident's progress notes were reviewed and they were identified as having impaired skin integrity in the spring of 2022.

An RN and the ADOC both indicated skin and wound assessments are completed using the skin assessment tool present under the assessment tab in PointClick Care (PCC).

Both residents' assessment section of PCC was reviewed and there were skin assessments completed on one specified date for each resident that indicated each resident had impaired skin integrity. The assessments completed do not include assessments of the size, wound margins, surrounding skin, exudate, odour, patient pain level and necrotic tissue type. The licensees Wound Assessment policy states these areas are to be assessed if a clinically indicated assessment is required. After this specified date, there were no further skin assessments completed under the assessment tab in PCC.

The residents' progress notes were reviewed. There were some skin assessments completed in the progress notes after an identified date, however on the dates the notes were entered, there was no clinically appropriate tool used under the assessment section in PCC.

As of summer 2022, the residents were both still being treated for impaired skin integrity.

This non-compliance presents a risk to residents in that their altered skin integrity is not being assessed in a consistent manner which could result in a deterioration and/or lack of treatment of the area being assessed.

This non-compliance was previously issued during inspection #2022_1148_0002.

[541]

Sources: Interviews with the ADOC and an RN, skin assessment, Progress notes, TAR, plan of care for two residents and policy #R-1660 titled Wound Assessment.

This order must be complied with by December 23, 2022

WRITTEN NOTIFICATION FAILURE TO COMPLY

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with FLTCHA s. 104(4)

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The Licensee has failed to comply with the conditions of Compliance Order (CO) #001 issued July 6, 2022 under inspection report 2022_1148_0002 with a compliance order due date of July 26, 2022.

Rationale and Summary

The licensee was required by CO #001 under inspection #2022_1148_0002 to be in compliance with FLTCA, 2021 s. 6(1)c.

The licensee had failed to ensure that the nutritional plans of care for seventeen identified residents provided clear direction related to diet textures, resulting in issuance of CO #001.

Compliance Order #001 required the home to:

- Review all residents' nutritional plans of care related to diet texture to ensure clear direction is provided to staff and others who serve food and fluids to residents. The nutritional plans of care include but are not limited to the diet type reports, care plans and physician orders.
- Keep a record of the date(s) this review occurred and who was involved.
- Ensure all staff who serve food and fluids to residents have, at point of service, access to the correct diet orders for residents.

A follow-up inspection was conducted on August 23-26, 29 and September 1, 2022. The Registered Dietitian stated that 50% of the residents' nutritional plans of care were reviewed, as there had not been time to complete a review of all residents. When inspector requested the record of the dates the plans of care were reviewed, none could be provided. Staff who serve food and fluids to residents did have access at point of service to the correct diet orders for residents.

Incorrect nutritional plans of care presents a choking risk if residents receive the incorrect diet texture.

Sources: The Registered Dietitian (RD) and food service workers.

[541]

An Administrative Monetary Penalty (AMP) is being issued on this written notification [AMP #001]

Notice of Administrative Monetary Penalty (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty [AMP #001]
Related to Written Notification NC #008

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Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$1100.00],** to be paid within 30 days of from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History

- Order #001 of inspection # 2022_1148_0002, FLTCA, 2021 s. 6(1)c

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(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, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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