Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 29, Mar 2, 5, 7, 2012	2012_041103_0011	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

DARLENE MURPHY (103)

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 a Registered Practical Nurse, a Registered Nurse, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed the resident health care record including the plan of care, progress notes, internal incident report, the medication administration record and the physician discharge summary.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. A resident sustained a fall in his/her bedroom. At the time of the fall, it was believed the resident may have struck his/her head and experienced seizure like activity.

The resident was assessed by the Registered Nurse (RN) at the time of the fall. An internal incident report was completed which stated "resident got out of bed and fell to floor. Bruise on right hip". There was no documented assessment in the resident health care record and there was no communication to subsequent shifts in regards to the resident possibly hitting his/her head or experiencing seizure like activity at the time of the fall.

Over the next two days the resident's condition deteriorated and the resident passed away. The Charge RN, working the day the resident passed away, was informed by a Personal Support Worker, working at the time of the resident fall, that the resident may have struck his/her head and had seizure like activity at the time of the fall.

The coroner was notified of an unexpected death and an autopsy was completed. The home's physician documented there was no evidence of a head injury at the time of the autopsy.

The licensee failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

Issued on this 7th day of March, 2012

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