Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2015	2015_200148_0012	O-001848-15	Complaint

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 23 and 24, 2015.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Registered Practical Nurse, Personal Support Workers, family members and identified resident. In addition, the inspector reviewed the resident's health care record and related information provided by the family including a letter related to the resident's discharge. The inspector also observed staff and resident interaction and resident care provided.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee did not ensure that the resident had the right to participate fully in making any decision concerning his or her discharge from a long-term care home.

Resident #1 was admitted approximately 1 year ago. In recent months concerns related to the provision of care and services have been brought to the Administrator and DOC's attention, primarily by the resident's family. The resident's family has indicated to both the LTCH Inspector #148 and to the home's management team that they are seeking placement outside of the long term care home and currently working with the local Community Care Access Center. At the time of this inspection, the resident nor the family had placement confirmed outside of this home.

On March 5, 2015, both persons identified as the resident's Power of Attorney (POA) for care and finance were provided with separate letters from the home's Administrator. The letter indicates that due to the fact the home can no longer provide the level of care the family is expecting that the resident will be discharged. One letter indicated that a discharge date was set for April 17, 2015.

At the time of this inspection, the licensee of the long term care home did not meet any requirement to discharge Resident #1 under section 145 of Regulation 79/10. Although the family and resident are working towards placement in a different home, the licensee did not have a signed request to be discharged from the home, as provided for in the Regulations.

The letter written by the Administrator indicates a decision concerning the discharge of Resident #1 was made without the resident or designated Power of Attorneys, having participated fully in making that decision. [s. 3. (1) 11. iii.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

The licensee did note ensure that each resident of the home receives oral care to maintain the integrity of the oral tissues that includes, physical assistance or cuing to help a resident who cannot, for any reason, brush his or her teeth.

A concern was brought to LTCH Inspector #148 by the family of Resident #1 related to the provision of adequate oral care. Resident #1 has right sided weakness due to disease process. The resident indicated to the inspector that he/she, has primarily used his/her right hand to provide oral care. The resident reported that due to the lack of function on the right side, he/she is no longer able to perform oral care and has found that some staff will only provide set up assistance leaving the resident to attempt oral care with his/her left hand, whereby he/she is not successful.

Inspector reviewed the resident's health care record and spoke to staff who care for Resident #1. It was confirmed that the plan of care indicates the resident is to be provided set up assistance and supervised with oral care and that this was the understanding of staff related to the resident care needs.

As per the resident, staff and plan of care, Resident #1 is not being provided the physical assistance required to ensure oral care. [s. 34. (1) (b)]

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Issued on this 20th day of April, 2015

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

Original report signed by the inspector.