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
Aug 28, 2015	2015_288549_0022	O-002356-15	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

RENA BOWEN (549)

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): August 24, 25, 26, 27, 2015

During the course of the inspection, the inspector(s) spoke with several Residents, the President of the Resident Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Social Worker and Recreation Supervisor, an Activity Aide, the Assistant Director of Care, the Director of Care and the Administrator.

The Inspector also reviewed resident health records including physician's order sheets and medication administration records, restorative care flow sheets, activity participation records, activity monthly calendars, Resident Council meeting minutes and the homes Skin and Wound Care policy #R-1615 and #R-1660.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of Resident #001's physician orders indicated that on a specific date in June 2015, a physician ordered pain medication to be given at specific times of the day for Resident #001 to manage the resident's pain.

On June 2, 2015, RN #106 received a telephone order from the physician to hold Resident #001's pain medication until the physician reassessed on a specific date in June 2015.

A review of the Resident #001's Medication Administration Record (MAR) for the month of June 2015 indicated that Resident #001 received the pain medication at specific times on a specific date in June 2015. This is after the medication order received from the physician stated the medication was to be held on a specific date in June 2015. Resident #001 received three doses of the pain medication after the medication was ordered to be held. The MAR did indicate that the pain medication was held starting a specific date in June 2015.

Inspector #549 reviewed the MARS with the DOC and Charge Nurse who confirmed that the pain medication was not administered to Resident #001 in accordance with the directions for use specified by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #1's Substitute Decision Maker (SDM) was given the opportunity to participate fully in the development and implementation of the plan of care.

Resident #001 was admitted to the home on a specific date in March 2011. The resident is independently mobile with the assistance of a mobility devise. He/she was observed on several occasions during the inspection to be in different parts of the home walking on his/her own with the assistance of the mobility device.

On a specific date in February 2015 the following was noted in the resident's progress notes by RPN # 101: Staff noted a large abrasion on a specific part of the body with area cleansed and dressing applied.

A skin assessment was completed on a specific date in February 2015 by the registered staff indicating that the resident had an abrasion measuring 4.25cm in length and 0.4 cm in width.

Review of Resident #001's Wound Assessment and Treatment Record indicates that the treatment for the abrasion was initiated on a specific date in February 2015, it occurred every other day and was stopped on a specific date in March 2015 as the abrasion had healed.

On a specific date in February 2015 the resident's progress notes indicate that the SDM for Resident #001 contacted the home requesting information as the resident's sitter sent an e-mail to the SDM indicating that the resident had an abrasion on a specific part of his/her body. The progress note entry also indicates that the SDM was not notified of the abrasion.

The ADOC confirmed with Inspector # 549 that the home did not notify the SDM of Resident # 001's abrasion and therefore the SDM was not given an opportunity to participate fully in the development and implementation of the plan of care for Resident #001. [s. 6. (5)]

Issued on this 28th day of August, 2015

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

Original report signed by the inspector.