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_0023	O-002487-15	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, a Family Member, Personal Support Workers (PSW),Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Social Worker, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The Inspector also reviewed several resident health care records including the psychogeriatric consults, medication administration records and observed care being provided.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #002.

Resident #002 was admitted to the home on a specific date in April 2014. Resident #002 has exhibited responsive behaviours.

During an interview RPN #103 indicated to Inspector #549 that a specific occurrence has been identified as one of Resident #002's responsive behaviour triggers. RPN #103 indicated that there are specific interventions for Resident #002 related to the identified triggers.

PSW # 101 provides direct care to Resident #002. The PSW indicated during an interview with Inspector #549 that Resident #002 will get upset and his/her behaviours will increase when a specific task is being completed. PSW #100 indicated that Resident #002 becomes agitated if another resident receives care before him/her.

The current written plan of care was reviewed by Inspector #549. The written plan of care does not identify the specific triggers for Resident #002 or the interventions required to manage the identified triggers.

The DOC indicated that she is aware of the specific triggers for Resident #002's responsive behaviour.

On August 25, 2015, during an interview the DOC indicated to Inspector #549 that the home's expectation is that the responsive behaviour triggers and interventions be identified in the written plan of care for Resident #002, to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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.