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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2016	2016_200148_0035	006084-14, 000821-15, 002907-15, 020520-15, 027040-15, 027963-15, 035490-15, 028887-16	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): October 4, 5, 6 and 12, 2016

This inspection included eight critical incident reports, one related to an alleged staff to resident abuse and seven related to incidents causing injury to residents that resulted in the resident being sent to hospital and significant health change.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Life enrichment staff, Staffing clerk, Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers and residents.

In addition, the Inspector also reviewed resident health care records including documents related to the fall prevention program, reviewed the home's policy to promote zero tolerance of abuse and documents of the home's investigation into an identified alleged abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee report to the Director the results of every investigation undertaken related to the immediate investigation of abuse of a resident.

On a specified date, a report was made to the Director/MOHLTC through the critical incident electronic reporting system describing a report made two days prior to RN #100. The critical incident indicated that resident #001 reported to have been hit by two staff members. The critical incident report went on to describe that the home's DOC had initiated an investigation and that a registered staff would be present when care is provided.

The report to the Director was reviewed and discussed with the home's DOC who had completed the report. It was demonstrated that the report did not include information related to the home's results of the investigation. [s. 23. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

On a weekend date, a person approached RN #100 to report that resident #001 had indicated that two staff had hit him/her. In a progress note RN #100 documented that she acknowledged the reporting of suspicion of abuse and advised there be a registered staff present when care is being provided.

On the following Monday, a report was made to the Director/MOHLTC through the critical incident electronic reporting system describing the report made to RN #001 and that an investigation had been initiated. Inspector #148 discussed the reporting structure in the home for abuse and neglect of residents with the home's DOC. She reported that RN #100 reported the information obtained on the weekend to the DOC, via email. The DOC indicates that she does not have access to email on the weekends and would have received the report on the Monday, at which time she made the report to the Director/MOHLTC.

During discussion with the home's DOC it was confirmed that the home has a process in place for staff to follow on the weekends for reporting of such incidents including calling the after hours pager (Director/MOHLTC) and/or manager on call. It was confirmed that RN #100 would have been the charge RN and supervisor in the building at the time of the reported alleged abuse.

The licensee did not ensure that a report was made immediately to the Director, when RN #100 had reasonable grounds to suspect abuse of a resident. [s. 24. (1)]

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Issued on this 13th day of October, 2016

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

Original report signed by the inspector.