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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 14, 2016	2016_200148_0042	013534-16	Resident Quality Inspection

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), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 7, 8 , 9 and 10, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident and Family Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Housekeeping aides, residents and family members.

In addition to this, the Inspectors reviewed resident health care records and associated documents and resident council meeting minutes. Inspectors observed medication administration, the resident's environment, resident care and services and staff/resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical

device if the restraining of the resident is included in the resident's plan of care.

Resident #016 was observed in bed with two long bed rails in the up position. The resident conveyed to the Inspectors that the bed rails were to keep him/her in the bed. Inspector #148 spoke with three PSW staff members who indicated that the bed rails are used for positioning and to keep the resident from transferring out of bed unassisted. The staff members noted that the resident has limited insight into abilities and that the resident is not safe to transfer from the bed, describing occurrences whereby the resident has fallen while transferring him/herself.

The plan of care indicates the use of two bed rails (length not described) to be used as a personal assistive safety device. In accordance with section 33 (6) of the Act, when a device is used to restrain rather than to assist the resident with an activity of daily living, section 31 of the Act (restraint) applies.

The two long bed rails in use for resident #016, are to prevent the resident from self transferring out of bed and incurring injury, in addition to the use as a positioning aid. The use of the bed rails as a restraint is not included in the resident's plan of care. [s. 31. (1)]

2. Resident #002 was observed to be seated in a tilt wheelchair with lap belt and tilt applied. After speaking with the resident and review of the health care record it was determined that the resident is not able to release the lap belt. The Inspector spoke with both the resident and two PSWs responsible for the resident's care. The resident has the lap belt applied at all times when seated in the wheelchair and was described as being used as a restraint to keep the resident from coming out of the chair. The tilt is usually applied and was described as being used for comfort. When asked by the Inspector, PSW #106 indicated that when the tilt is applied the resident is not at risk for falling out of the chair and may not require the lap belt at these times.

The plan of care was reviewed and did not include the use of either the lap belt or tilt application of the wheelchair for resident #002. Further to this, requirements of section 31 (2) of the Act were also found to be deficient including physician order, reasonable restraining and documented monitoring. [s. 31. (1)]

3. Resident #012 was observed to be seated in a wheelchair with tray and wheelchair with tilt application. Observation of the use of the tray were both during and outside of meal/snack times.

The Restraint Monitoring Record indicates the resident uses a back clip belt and two raised bed rails. The documentation does not specify what device is applied at what time, nor that repositioning and monitoring is completed as required by s.31 (3) of the Act and s.110 of the Regulations 79/10. The record reviewed does not support the use of a tray. In addition, observations and resident and staff interviews indicate that there is no back clip belt in use for this resident.

The Inspector spoke with PSW #106, at which time the resident was in the wheelchair in the resident's bedroom with both tilt and tray applied. When asked, PSW #106 indicated that the tray was used for meals to help the resident to eat. When the Inspector noted to the PSW that the resident was not currently eating or drinking, she noted the tray was also to help keep the resident safe. PSW #106 then noted that the tray is applied whenever the resident is seated in the wheelchair due to the resident's positioning, describing that if the tray were not in place the resident may fall out of the chair.

The plan of care was reviewed by the Inspector for resident #012. The plan of care describes the use of a restraint, noting application and repositioning requirements, without specificity to the device in use. In addition, the plan of care describes the tray to be used for meals/activities under mobility. The plan of care does not clearly include the use of the tray as a restraint. [s. 31. (1)]

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 the restraining of a resident by a physical device is included in the resident's plan of care and that requirements of section 31 are satisfied prior to the inclusion of a restraint in the plan of care, to be implemented voluntarily.

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Issued on this 14th day of November, 2016

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

Original report signed by the inspector.