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
Mar 23, 2017	2017_505103_0010	029490-16, 030189-16, 033858-16	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

DARLENE MURPHY (103)

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): March 14, 21, 22, 2017

The following intakes were included in this inspection:
Log #0029490-16 (resident fall),
Log #030189-16 (alleged staff to resident abuse),
Log #033858-16 (alleged staff to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the home's zero tolerance of abuse policy, staff education records for abuse training, and the home's investigation notes related to the alleged incidents of abuse.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The following finding relates to Log #033858-16:

1. The licensee has failed to ensure the home's zero tolerance of abuse policy was complied with.

As defined under Ont. Regulation 79/10, s. 2 (1), verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

On an identified date, derogatory comments were overheard being made to resident #003. Staff were interviewed and reported hearing PSW #107 calling the resident degrading names in relation to the resident's looks and the manner in which the resident was eating. Staff also reported overhearing an inappropriate song being sung to resident #003 that related to the meal being served. Staff reported the comments were made in a voice loud enough to be heard by all who were seated in the dining area.

The incident was deemed by the staff member to be verbally and emotionally abusive in nature at the time of the incident, but the staff member failed to report the incident until several days later when it was brought forward to a manager.

The home's abuse policy titled, "Zero Tolerance of Abuse and Neglect" was reviewed. Under "Reporting", the policy stated an alleged or witnessed incident of abuse or neglect shall be immediately reported to the charge nurse, supervisor, department manager or Administrator as appropriate.

The staff member failed to immediately report a witnessed incident of resident abuse. [s. 20. (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 all staff immediately report any suspected, alleged or witnessed incidents of abuse immediately to the charge nurse, supervisor, department manager or Administrator, to be implemented voluntarily.

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 :

The following finding relates to Log #030189-16:

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

On an identified date, PSW #100 had been providing morning care to resident #001 when the resident become combative and struck the PSW. The PSW left the resident room and indicated to PSW #101 that she would re-approach the resident again in ten to

fifteen minutes. PSW #101 insisted on completing the resident's care at that time and entered the resident's room. PSW #100 indicated in a written statement that PSW #101 was very loud and using an angry voice when she spoke with resident #001 such that comments could be heard through the closed door. RPN #104 was interviewed and stated he spoke with resident #001 who stated PSW #101 forced them to get dressed and was rough when assisting them. The RPN also stated the resident had requested something for pain just prior to the incident and believed this was the reason the resident did not want to get dressed at that time.

A short time later, resident #002 had rang the bell to request a bed pan. The resident required the assist of two staff and a mechanical lift to be transferred from the wheelchair to the bed. PSW #100 indicated PSW #101 raised her voice with resident #002 and told the resident repeatedly that if they wanted to go to bed now, they would not be able to go to bed later. During the transfer, resident #002 was incontinent and this evoked PSW #101 to begin yelling at the resident again. PSW #100 asked PSW #101 to leave the room and apologized to resident #002.

The incidents were reported to RN #109 by PSW #100. RN #109 was interviewed in regards to her actions in response to the incidents. She indicated she counselled PSW #101 that she needed to be more patient and monitored the PSW for the remainder of the shift. The RN indicated she also reported the incident by means of an email sent to the ADOC so she could follow up on Monday upon her return to work.

The DOC was interviewed as the ADOC no longer works in the home. She stated the Registered Nurses are in charge of the building on weekends and after hours and are responsible to report all witnessed, suspected or alleged incidents of abuse to the Ministry of Health after hour's emergency pager. The DOC stated the number is available at each nursing station and is highlighted in yellow. The DOC further indicated emails sent to a manager during off hours would not be acceptable by the home as an immediate response could not be guaranteed.

The licensee failed to ensure witnessed incidents of verbal and emotional abuse were immediately reported to the Director. [s. 24. (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 a person who had reasonable grounds to suspect that abuse of a resident has occurred or may occur immediately report the suspicion to the Director, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The following finding relates to Log #030189-16:

1. The licensee has failed to ensure that care set out in resident #001's plan of care was provided as specified in the plan.

Resident #001's health care record was reviewed and indicated the resident was admitted to the home on an identified date and the resident had identified diagnoses. As outlined in WN #2, the resident had been combative with PSW #100 during the provision of morning care. The PSW left the resident room and planned to re-approach the resident in ten to fifteen minutes. PSW #101 insisted the care needed to be completed and proceeded to force the resident to get dressed and come to the dining room.

RN #109 was interviewed in regards to this resident. She stated the best approach is to leave the resident (as long as they are safe) and to re-approach them in ten to fifteen minutes as PSW #100 had done. RN #109 stated the re-approach is generally an effective intervention. She also stated in some instances it may be necessary to have an alternate staff member attempt the care when the re-approach proves to be ineffective. The RN went on to say that forcing the resident to complete the care would not be acceptable.

The DOC was also interviewed and stated the home has always promoted that staff need to re-approach when a resident becomes resistive to care. The DOC stated this is reinforced in GPA (Gentle Persuasive Approach) training that all front line staff receive.

PSW #101 failed to provide care to resident #001 in accordance with the resident's plan of care. [s. 6. (7)]

WN #4: 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 :

The following finding relates to Log #030189-16:

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

As outlined in WN #2, an alleged incident of verbal/emotional abuse occurred involving residents #001 and #002. The home submitted a critical incident on an identified date to report the incidents. The critical incident indicated the home was investigating the allegations and the alleged staff member responsible had been suspended pending the outcome of the investigation. To date of this inspection, the home did not further amend the report such that the results of the home's investigation were reported to the Director (MOHLTC). [s. 23. (2)]

Issued on this 23rd day of March, 2017

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

Original report signed by the inspector.