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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2018_702197_0026 (A2)	030066-18	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

Amended by JESSICA PATTISON (197) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

This report has been amended, at the request of the home, to extend the compliance due date to April 30, 2019.

Issued on this 12nd day of March, 2019 (A2)

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

Original report signed by the inspector.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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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

Amended by JESSICA PATTISON (197) - (A2)

Amended 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): November 19, 20, 2018

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Registered Nurse, a Nurse Practitioner, a Physician, a Personal Support Worker and a resident's Substitute Decision Maker (SDM).

The inspector also reviewed a resident's health care record, including progress notes, advance directives for care forms and hospital discharge notes.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 :

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

In the morning, on a specified date, resident #001 was assessed by RN #100 due to a PSW reporting that the resident was not themselves. The assessment by the RN was completed and indicated that the resident was suffering from acute symptoms and the Physician was informed and the POA was called and a

message left. The assessment also indicated the resident was a Level 2 and DNR (Do Not Resuscitate).

Resident #001 continued to be reassessed throughout the morning and early afternoon by registered staff and was also assessed by the Nurse Practitioner (NP). At the time the NP assessed resident #001, no distress was noted, one symptom had stabilized, while another remained.

According to the documentation, multiple attempts were made throughout the morning on this date to reach the resident's Substitute Decision Maker (SDM), with no success.

Mid to late afternoon, resident #001's SDM arrived at the home and according to the progress notes, requested that the resident be sent to the hospital.

The progress notes indicated that when staff called the hospital later that same day, the home was notified that the resident had suffered a specified medical incident and was being admitted.

Resident #001 returned to the home approximately 9 days later, with specified changes to their condition.

Progress notes and interviews with RN #100, NP #102, Physician #103 and the DOC, all indicated that the reason the resident was not transferred to hospital immediately on the specified date, was due to the Advance Directives for Care form signed by resident #001's SDM. This form, signed in 2017, indicated that resident #001 is a "Level 2 Advance Directive – Remain at Home", which is defined as follows:

"Your health care team will provide all medications and non-medicinal care interventions to relieve expected symptoms like pain, fever or breathing difficulties to ensure your comfort. No life prolonging interventions will be undertaken. Your family will be contacted. Your care will focus on symptom relief, comfort measures and allow for a natural death at home, not hospital."

Also on this form, underneath the definitions for level 1 and 2 advance directives, is the following statement:

"Note: In any case when there are acute, unexpected symptoms; an ambulance

will be called and a transfer to hospital will be arranged. Your physician or (on-call) physician will be contacted and your Power of Attorney or Substitute Decision Maker will be notified."

During an interview with resident #001's SDM, they indicated that due to the above statement on this form, their understanding was that the resident would have been sent to the hospital immediately on the date of the incident, even if the home could not reach them. They further stated that the resident would have wanted to be sent to hospital when suffering from acute, unexpected symptoms.

The Advance Directives for Care form, which is part of resident #001's plan of care, was not followed on the specified date. The resident was suffering from acute, unexpected symptoms and was not sent to hospital until over 6 hours later when the home received consent from the resident's SDM. The Advance Directives for Care form signed by resident #001's SDM indicated that the resident will be sent to hospital. It does not say the home will wait for consent, and therefore, was not followed. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 001

Issued on this 12nd day of March, 2019 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA PATTISON (197) - (A2)
Inspection No. / No de l'inspection :	2018_702197_0026 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	030066-18 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 12, 2019(A2)
Licensee / Titulaire de permis :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alfred O'Rourke

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 6(7).

Specifically, the licensee shall ensure that:

1) the Advance Directives for Care form is reviewed by the interdisciplinary team and that Physicians, Nurse Practitioners and Registered Nurses are educated on the form and
2) that the care set out in the plan of care of residents, related to Advance Directives, is reflective of the resident's current wishes and provided as specified in the plan.

Grounds / Motifs :

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

In the morning, on a specified date, resident #001 was assessed by RN #100 due to a PSW reporting that the resident was not themselves. The assessment by the RN was completed and indicated that the resident was suffering from acute symptoms and the Physician was informed and the POA was called and a message left. The assessment also indicated the resident was a Level 2 and DNR (Do Not Resuscitate).

Resident #001 continued to be reassessed throughout the morning and early afternoon by registered staff and was also assessed by the Nurse Practitioner (NP). At the time the NP assessed resident #001, no distress was noted, one symptom had

stabilized, while another remained.

According to the documentation, multiple attempts were made throughout the morning on this date to reach the resident's Substitute Decision Maker (SDM), with no success.

Mid to late afternoon, resident #001's SDM arrived at the home and according to the progress notes, requested that the resident be sent to the hospital.

The progress notes indicated that when staff called the hospital later that same day, the home was notified that the resident had suffered a specified medical incident and was being admitted.

Resident #001 returned to the home approximately 9 days later, with specified changes to their condition.

Progress notes and interviews with RN #100, NP #102, Physician #103 and the DOC, all indicated that the reason the resident was not transferred to hospital immediately on the specified date, was due to the Advance Directives for Care form signed by resident #001's SDM. This form, signed in 2017, indicated that resident #001 is a "Level 2 Advance Directive – Remain at Home", which is defined as follows:

"Your health care team will provide all medications and non-medicinal care interventions to relieve expected symptoms like pain, fever or breathing difficulties to ensure your comfort. No life prolonging interventions will be undertaken. Your family will be contacted. Your care will focus on symptom relief, comfort measures and allow for a natural death at home, not hospital."

Also on this form, underneath the definitions for level 1 and 2 advance directives, is the following statement:

"Note: In any case when there are acute, unexpected symptoms; an ambulance will be called and a transfer to hospital will be arranged. Your physician or (on-call) physician will be contacted and your Power of Attorney or Substitute Decision Maker will be notified."

During an interview with resident #001's SDM, they indicated that due to the above statement on this form, their understanding was that the resident would have been sent to the hospital immediately on the date of the incident, even if the home could not reach them. They further stated that the resident would have wanted to be sent to hospital when suffering from acute, unexpected symptoms.

The Advance Directives for Care form, which is part of resident #001's plan of care, was not followed on the specified date. The resident was suffering from acute, unexpected symptoms and was not sent to hospital until over 6 hours later when the home received consent from the resident's SDM. The Advance Directives for Care form signed by resident #001's SDM indicated that the resident will be sent to hospital. It does not say the home will wait for consent, and therefore, was not followed.

The decision to issue this non-compliance as a compliance order was based on the following:

The severity of this non-compliance is a level 3 (Actual Risk) as resident #001 was documented as showing specified acute symptoms and was not sent out to hospital for further assessment/treatment until over 6 hours later.

The scope of this non-compliance is determined to be a level 1 (isolated) as only one resident in the home was affected.

The home has a level 3 compliance history (1 or more related non-compliance in last 36 months). (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of March, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PATTISON (197) - (A2)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Ottawa Service Area Office