Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2021_621755_0002	004372-20, 004373-20, 004374-20, 004560-20, 018083-20, 018132-20, 019364-20, 019579-20, 022384-20	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

MANON NIGHBOR (755), WENDY BROWN (602)

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): January 13, 14, 15, 18, 19, 20, 21, 22, 2021.

During this inspection follow up orders, critical incidents and inquiries were inspected:
Logs #004372-20; 004373-20, 004560-20 follow up orders from inspection # 2020-664604-0005, related to alleged neglect, abuse and medication.
Log #004374-20 follow up order from inspection # 2020-621755-0003, related to hydration and nutrition.
Log #022384-20, CI #2640-000021-20; log #018132-20, CI #2640-000018-20 and log # 018083-20, CI # 2640-000017-20 related to alleged resident to resident sexual responsive behavior.
Log #019579-20, CI #2640-000020-20 related to injury, succumbed from outdoor incident.
Log #019364-20, CI #2640-000019-20 and log #025852-20, CI # 2640-000025-20 related to falls.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Dietician (RD), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Coordinator, Life Enrichment personel.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #002	2020_664602_0005	602
O.Reg 79/10 s. 135. (1)	CO #003	2020_664602_0005	602
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_664602_0005	602
O.Reg 79/10 s. 68. (2)	CO #001	2020_621755_0003	755

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	Légende 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no medication is administered to a resident unless the medication has been prescribed for the resident.

A resident was administered another resident's medication. The wrong medication bin was accessed, placing the resident at potential risk for various negative side-effects. The error was immediately recognized; the resident was assessed and monitored with no subsequent ill effects.

Sources: The Long-term Care home's medication incident report - progress notes and interview. [s. 131. (1)]

Issued on this 8th day of February, 2021

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

Original report signed by the inspector.