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
Dec 17, 2021	2021_873602_0041	014121-21, 015206-21, 015384-21	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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 2, 3 & 6-10, 2021

The following inspections were completed:
Log #015384-21/CIS #2640-000023-21 - regarding improper care/treatment of multiple residents.
Log #015206-21/CIS #2640-000020-21 - regarding a fall causing injury and transfer to hospital.
Log #014121-21/CIS #2640-000025-21 - regarding a fall causing injury and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC)/ Infection Prevention & Control (IPAC) management lead, the Director of Care (DOC), the Environmental Services Supervisor, Environmental Services staff, the Support Services Supervisor, and IPAC screening staff.

In addition, the inspector reviewed resident health care records: including plans of care, medication administration records & progress notes, relevant policies and procedures, medication incident reports and made resident care & service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Medication Administration Medication Pass policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. Specifically, the licensee did not follow Medication Pass Policy 3-6.

Medication Pass Policy 3-6 outlines that staff administering medications are to ensure: the resident is ready to take their medication, that the resident has taken their medication and medications that are not administered are placed in a designated container on the medication cart and then placed with surplus medications for destruction. A Registered Practical Nurse (RPN) administered a resident their medication while they were laying supine in their bed; the resident subsequently vomited. The RPN administered another resident their medication while they were sleeping; the resident startled awake and spit out the medication. In a third incident, the RPN left a resident's medication crushed in applesauce at the dining room table where it was later found and discarded by another staff.

Sources: Critical Incident System (CIS) Report, Pharmacy Policy and Procedure Manual policy 3-6 procedure items 2. 6. & 9. (revised January 2018) and interview(s) with the Director of Care (DOC), the Assistant DOC and registered nursing staff. [s. 8. (1) (b)]

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 their medication administration policy and procedures are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was safely repositioned.

A RPN was observed repositioning a resident who was sitting in a wheelchair; the RPN placed their arms under the resident's axilla and attempted to lift them. The wheelchair brakes were not on and the chair moved backwards. The resident suffered an injury as a result of the RPN's improper positioning technique.

SOURCES: CIS Report, resident progress notes and plan of care, and interviews with the ADOC and other staff [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a residents medication was stored according to narcotic and controlled drug regulations.

A RPN left a resident's medication at the nursing desk; an area accessible by residents. Narcotic and controlled drug regulations indicate that certain medications are to be stored in a locked narcotics bin in a locked medication cart.

Sources: CIS Report, Pharmacy Policy and Procedure Manual policy 3-4 (revised June 2018) and interview(s) with the DOC, ADOC and registered nursing staff. [s. 129. (1) (b)]

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 medications are safely stored and supervised in accordance with applicable legislation, to be implemented voluntarily.

WN #4: 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).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A RPN administered a resident's medication to another resident; in a subsequent incident, the same RPN gave a third resident's medications to a fourth resident. Administering medications that have not been prescribed can harm a resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On three separate dates a RPN administered medications to four residents at an incorrect time. On two other separate dates the same RPN administered three residents an incorrect dose of their medications and on three additional dates, six residents did not receive their prescribed medications. Failing to administer medications, and/or administering the incorrect dose of a medication at the incorrect time can result in resident harm.

Sources: CIS Report, resident medication records, medication incident reports, and interviews with the DOC and the ADOC. [s. 131. (2)]

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 residents receive only their prescribed medication in accordance with directions specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to assist residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. On two separate mealtime observations in a unit dining area resident hands were not cleaned prior to attending or within the dining area. The ADOC and Personal Support Worker (PSW) staff indicated that performing hand hygiene before and after meals was not always completed; neglecting hand hygiene at this time increases the risk of virus transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), IPAC Checklist A2, resident care unit IPAC observations and interviews with the ADOC/IPAC management lead and PSW staff. [s. 229. (9)]

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 residents are assisted to perform hand hygiene before and after meals, to be implemented voluntarily.

Issued on this 4th day of January, 2022

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

Original report signed by the inspector.