Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: November 25, 2024
Inspection Number: 2024-1148-0005
Inspection Type: Critical Incident
Licensee: Sherwood Park Manor
Long Term Care Home and City: Sherwood Park Manor, Brockville

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 19, 20, 21, 2024

The following intakes were completed during this Critical Incident (CI) inspection:
Intake #00123056/CI#2640-000018-24 related to a complaint regarding an allegation of staff to resident verbal abuse.
Intake #00124717/CI# 2640-000022-24 related to a fall sustained by a resident that resulted in a significant change in condition.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure the provision of care set out in the plan of care was documented, specifically related to the hourly safety checks for a specific resident when a restraining device was applied on specific dates.

Sources: September 2024 Point of Care documentation, progress notes, interview with two staff members, Restraint Policy (revised January 25, 2023).

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (b)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and

This licensee failed to ensure the home's complaints policy includes written procedures which include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry.

Sources: A staff member, policy titled Complaints (revised September 1, 2024).

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WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure the home's complaint policy included the procedure to immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations.

Sources: A staff member, policy titled Complaints (revised September 1, 2024)

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (2) 1.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee failed to ensure that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. Specifically, a physician order was not obtained prior to the implementation of restraining devices for a specific resident on a specific day.

Sources: Interview with two staff members, progress notes, Personal Assistance Services Device (PASD) Consent form, home policy-Restraint (revised- January 25, 2023), review of physician order records