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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2014	2014_347197_0011	O-000398-14	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

JESSICA PATTISON (197)

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): May 29 & 30, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Nursing, a Registered Nurse, Registered Practical Nurses, a resident and a resident's family member.

During the course of the inspection, the inspector(s) reviewed a resident's health care record, the home's complaint log, a complaint, the home's response to the complaint and the Daily Communication Meeting book.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(5) in that a designate of a resident was not provided the opportunity to participate fully in the development and implementation of the plan of care.

According to the health care record, Resident #1 has two designates who are joint Powers of Attorney (POA) for the resident's personal care.

During a phone interview with one of the residents POAs on May 28, 2014, it was stated that the home had not been contacting both POAs regularly with updates on the resident's health and that the home usually only calls one of them. The POA interviewed on May 28, 2014 stated that this has been an ongoing issue.

Resident #1 was interviewed on May 29, 2014 and indicated wanting both POAs to be contacted regarding changes in health status.

Resident #1's progress notes were reviewed for the past year and showed that on seven different dates only one POA was notified of changes to the resident's health.

Staff member #S101 was interviewed and stated that usually the Registered Nurse in the home will call POA's to update them regarding changes in a resident's health. She said that typically in a case where a resident has two POA's, the one listed first would be called and that POA would notify the other. She also stated that if both POA's wanted to be notified then the home would do this. Staff member #S101 went on to say that in the case of Resident #1, all staff were instructed around the end of April 2014 to call both POA's. She stated that prior to this instruction staff would have called only the POA that was listed as Resident #1's first contact. [s. 6. (5)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 22(1) in that the home received a written complaint concerning the care of a resident and operation of the long-term care home and did not forward the complaint immediately to the Director.

On April 25, 2014, Resident #1's POA sent a written complaint to the Administrator of the home outlining concerns with not being contacted regarding changes in the resident's health.

The Administrator confirmed in an interview on May 29, 2014 that he did receive this written complaint, but did not forward it to the Director. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(1)1 in that a written complaint made to the home was not responded to within 10 business days of receiving the complaint.

Resident #1's POA for personal care sent a written complaint to the Administrator of the home on April 25, 2014.

The written complaint outlined concerns with not being contacted regarding changes in the resident's health.

The Administrator indicated on May 29, 2014, that he had not responded to this written complaint until the time of the inspection (May 29, 2014) and provided the inspector with a copy of the response sent to Resident #1's POA. [s. 101. (1) 1.]

Issued on this 23rd day of June, 2014

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