Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 10 and 11, 2011	2011_117_2640_10Jan215242	Critical Incident Log # O-000052

Licensee/Titulaire

Sherwood Park Manor
1814 County Road 2 East
Brockville, ON
K6V 5T1
Fax: (613)342-3767

Long-Term Care Home/Foyer de soins de longue durée

Sherwood Park Manor
1814 County Road 2 East
Brockville, ON
K6V 5T1
Fax: (613)342-3767

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

The purpose of this inspection was to conduct a critical incident inspection related to skin integrity and the provision of baths to a resident.

During the course of the inspection, the inspector spoke with the home's Administrator, the home's Assistant Director of Care; to the home's Maintenance Manager, to a day shift unit Registered Nurse, to three Personal Support Workers, to two residents.

During the course of the inspection, the inspector reviewed two residents health care records, reviewed the home's 24-hour nursing report, reviewed the home's Resident Care Manual – Tub Bath policies (R-790), reviewed the home's resident bath schedule, reviewed the home's water temperature monitoring logs and noted water temperatures in all of the home's 5 tub/shower rooms.

The following Inspection Protocol was used during this inspection:

- Accommodation Services : Maintenance
- Personal Support Services

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. The home's North tub and shower room has no privacy curtain between the Arjo tub and square tub/shower stall.

2. On January 11 2011, an interviewed Personal Support Worker states several times per week, two residents are bathed in the North tub and shower room, at the same time.

Inspector ID #:	# 117

WN #2: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s. 6 (9) The licensee shall ensure that the following are documented:

2. The outcomes of the care set out in the plan of care.

Findings:

1. On January 7, 2011 a resident's skin became red during his/her scheduled tub bath. The resident states that his skin was red for up to half an hour after his/her bath.

2. Two interviewed Personal Support Workers state that they did not report the resident's red skin to the Registered Nurse or to the Registered Practical Nurse until January 10, 2011.

3. Two interviewed Personal Support Workers state that they applied cream to the resident's skin and monitored his/her skin until the redness resolved but did not report their interventions to the Registered Nurse or to the Registered Practical Nurse.

4. There is no documentation in the resident's health care record regarding his/her skin being assessed, skin care interventions being provided and monitoring of his/her skin on January 6, 2011 or afterwards.

Inspector ID #:	# 117

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). January 21, 2011