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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 28, 2021	2021_873602_0010	002057-21, 003038-21, 003420-21, 005869-21, 006550-21	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

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

This inspection was conducted on the following date(s): April 19, 21 - 23, 26 & 27, 2021

The following inspections were conducted
Log # 003420-21, 003038-21, 006550-21 /CIS # 2640-000005-21, 2640-000003-21& 2640-000009-21 respectively - regarding falls resulting in injury and transfer to hospital.
Log # 005869-21 /CIS # 2640-000008-21 – regarding alleged resident to resident abuse.
Log # 002057-21/ CIS # 2640-000002-21 – regarding a wound sustained from mobility equipment requiring 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), Housekeeping staff, the Physiotherapist, the Physiotherapy Assistant, Dietary staff, IPAC screening staff and the Administrator.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 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 participate in the IPAC program by not assisting 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. IPAC lunch hour observations in the main dining area revealed resident hands were not cleaned prior to attending or within the dining area(s). 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, 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 all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.