Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 26, 2024
Inspection Number: 2024-1533-0003
Inspection Type: Complaint Critical Incident
Licensee: Corporation of the County of Bruce
Long Term Care Home and City: Brucelea Haven Long Term Care Home - Corporation of the County of Bruce, Walkerton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-21, 24-28, 2024, and July 2-5, 2024

The following intake(s) were inspected:

- Intake: #00112041 - Complaint related to skin and wound care
- Intake: #00115518 - Complaint related to nutrition
- Intake: #00112693, related to infection prevention and control
- Intake: #00117118, related to an injury of unknown cause

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident exhibiting a pressure injury was reassessed at least weekly by a member of the registered nursing staff.

Rationale & Summary:

A resident had a pressure injury. For four weeks the residents skin assessments for their wound were not completed in full:

- The residents wound assessment had incomplete section for length of time the wound had been present, wound bed, exudate, periwound, wound pain, orders, treatment, and progress.

- The residents wound assessment had incomplete section for length of time the wound had been present, periwound induration, woundbed-other, wound pain, orders, and progress.
- The residents wound assessment had incomplete section for length of time the wound had been present, woundbed-other, periwound- induration, periwound temperature, wound pain, orders, modalities, and progress.
- The residents wound assessment had incomplete section for length of time the wound had been present, wound bed-other, wound pain frequency, orders, treatment, and progress.

The Director of Care (DOC) stated the expectation was that skin assessments were completed in full, and skin assessments were not completed in full.

By not completing wound assessments for the resident as required, their wound could have worsened without staff's knowledge.

Sources: Interview with DOC, Skin and Wound Assessments

COMPLIANCE ORDER CO #001 Skin and wound care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review and revise the home's current process registered staff are to follow when a resident's wound shows signs and symptoms of infection to ensure immediate treatment and interventions to promote healing and prevent infection are implemented. Revisions should include but not be limited to who the registered staff should notify when wounds worsen, and the timeframe in which this is to occur. This process should be documented.

2. Train all registered staff on the above-mentioned process. The licensee must keep a documented record of the training and education provided, the date completed, and who completed the education.

3. Conduct an audit of all current pressure ulcers in the home to determine if signs and symptoms of infection were identified and treated in a timely manner, and to determine if these assessments were completed in full. The audit should include the date the wound was assessed, if any signs and symptoms of infection were identified, what actions the staff took if signs and symptoms of infection were identified, if the assessments were completed in full, and any corrective action needed. The audits are to continue until the home is identified to be in compliance with this order.

Grounds
The licensee has failed to ensure that a resident received immediate treatment and interventions to promote healing and prevent infection of their wound.

Rationale and Summary
During the following 18 days the following occurred:

- The wound was documented to have increased measurements, drainage, and pain. The wound was warm, odourous and had heavy purulent exudate present.
- The Nurse Practitioner (NP) ordered observations of the resident and a wound swab. Staff did not complete the swab as ordered.
- The resident's wound was documented to be poor, with foul odour and leaking dressings.
- The resident's wound was documented to have foul odor and the resident began experiencing a change in condition. The physician was made aware of the wound's worsening condition and the resident's change in condition at that time.
- The resident was started on treatment.
- The NP ordered a swab on the wound, and this was carried out the same day.
- The wound swab came back as positive for infection.
- The resident became less verbal and unable to perform tasks they had previously been able to do.
- The resident died. Their cause of death was linked to the wound infection.

The DOC indicated that when a wound worsened, staff were expected to notify the NP or physician on the same day this occurred. They indicated you did not want to delay starting treatment if it was deemed appropriate.

The delay in providing treatment and interventions for the resident's wound may have contributed to its deterioration and the resident's death.

Sources: Interview with DOC, interview with PSW, progress notes, skin and wound assessment, Prescriber's Digiorders, fax to Physician.

This order must be complied with by September 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.