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

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

Original Public Report

Report Issue Date: March 28, 2024	
Inspection Number: 2024-1541-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Corporation of the County of Dufferin	
Long Term Care Home and City: Dufferin Oaks, Shelburne	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature**
Additional Inspector(s) Gabriella Del Principe (741734)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7-8, and 11-15, 2024

The following intakes were inspected:

- Intake #00106830, related to care concerns and resident's rights
- Intake #00107927, related to falls preventions and management.

The following intakes were reviewed:

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- Intake #00103862, and intake #00106774, related to falls preventions and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care relating to bathing was reviewed and revised when the resident's care needs changed.

Rationale and Summary

A resident's plan of care documented that the resident required assistance from staff with their baths.

The home's policy related to baths documented that staff were to apply a safety device to avoid injuries during transfers and if a resident refused to wear it, this was to be indicated in their care plan.

A Personal Support Worker (PSW) said a resident refused to wear the safety device.

There were no revisions of the resident's plan of care to indicate the resident's refusal.

Sources: a resident's clinical records, the home's Bathing policy (March 2019), Alenti -Bath Chair policy (March 14, 2024), and interviews with a Registered Nurse (RN), the Director of Care (DOC) and other staff. [758]

Date Remedy Implemented: March 13, 2024

WRITTEN NOTIFICATION: Involvement of resident, etc

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development of the resident's plan of care related to continence care.

Rationale and Summary

A resident's plan of care documented that the resident was to wear two continence care products at the same time.

The home's continence care product guidelines discouraged the practice of using more than one absorbent product at a time due to multiple associated risks.

A Registered Nurse (RN) said the resident's SDM was not informed about these risks, as required.

By not allowing the resident's SDM to fully participate when making decisions about the resident's continence care needs, their SDM may not be able to make an informed choice regarding the continence care products to minimize these risks.

Sources: a resident's clinical records, the home's continence product guidelines, and interviews with an RN and other staff. [758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

The licensee has failed to ensure that the skin and wound care program provided for treatment and interventions related to two types of pressure injuries.

Rationale and Summary

The home's Wound Care and Altered Skin Treatment policy documented that residents with pressure related injuries were to have these pressure areas staged in accordance with the National Advisory Pressure Ulcer Panel (NPUAP). With any alteration of skin integrity, an appropriate assessment, treatment, documentation and care planning was to be carried out for each resident as indicated in the skin and wound protocols within the policy. For general treatment of pressure injuries, staff were to refer to Skin and Wound Protocol Appendix A.

The Skin and Wound Care Protocol in Appendix A of the home's policy did not include treatment modalities or interventions for two types of pressure injuries.

A resident was noted with two pressure injuries.

There was no direction in the policy on how to treat this type of pressure injuries and the home did not consult a specialist or general practitioner to assess these wounds.

One of the resident's pressure injuries had a treatment plan for staff to follow when dressing the wound. It was unknown how this was determined to be the correct treatment.

The resident's plan of care did not include directions on how to treat their second pressure injury. As a result, a review of the weekly assessments for the second pressure injury identified that staff were using various dressings for this area.

Approximately one month after the pressure injuries were first noted, a referral was sent to the home's Wound Care Coordinator (WCC) indicating that the treatment for one of the pressure injuries was ineffective. New orders were initiated for this area, however, there continued to be no orders for the second pressure injury.

Two weeks later, a second referral was sent to the home's WCC indicating that both pressure injuries deteriorated. There was no change in the treatment and there were no directions for the treatment of the second pressure injury.

The home’s WCC acknowledged these gaps and inconsistencies in the treatments applied to the resident’s pressure injuries. The Nurse Practitioner and/or the physician were not informed about these wound treatments before being initiated.

The DOC acknowledged that the home’s Skin and Wound Care Program did not include treatment modalities and interventions for this type of pressure injuries and that the Nurse Practitioner and/or the physician should be informed for treatment options.

By not including directions to staff on what actions to take for treatment and interventions for two types of pressure injuries in the home’s skin and wound

program, staff implemented various treatments that were not ordered which may have contributed to the deterioration of the resident's pressure injuries.

Sources: a resident's clinical records, the home's Wound Care and Altered Skin Treatment policy (November 2023), the home's Skin and Wound Program (November 2023), and interviews with the home's WCC and the DOC. [758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident received immediate interventions to relieve pain related to their pressure injuries.

Rationale and Summary

A resident had two pressure injuries.

The resident's wound assessments for one of the pressure injuries documented that the resident had wound pain on two separate occasions.

Additionally, on one occasion, the resident was noted with pain related to the second pressure injury.

There was no indication of any immediate interventions implemented to relieve the resident's pain on any of these occasions.

The home's WCC said if the resident was noted with wound pain, staff should have assessed the pain and implemented interventions to relieve pain before continuing with the wound dressing.

By not providing immediate interventions to relieve the resident's wound pain increased the risks associated with unrelieved pain.

Sources: a resident's clinical records and interviews with the WCC and other staff. [758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 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's pressure injuries were reassessed

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at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident had multiple areas of altered skin integrity, including two pressure injuries. The resident's electronic treatment record (eTAR) documented that wound assessments for these areas were to be completed weekly.

There were no weekly wound assessments completed for the resident's two pressure injuries for one week. The following week, the resident's pressure injuries deteriorated.

On multiple occasions, the weekly wound assessments for the two pressure injuries were incomplete.

The home's WCC said skin and wound assessments should be completed weekly, and include all the information listed in the assessments.

Gaps in the completion of the weekly wound assessments of the resident's pressure injuries increased the risk that appropriate interventions were not implemented in a timely manner when the areas started to deteriorate and made it difficult to evaluate the wound progress and the effectiveness of the treatment provided.

Sources: a resident's clinical records, and interviews with the WCC, the DOC and other staff. [758]