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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2021	2021_725522_0004	022833-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Southwood Lakes
1255 North Talbot Road Windsor ON N9G 3A4

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

JULIE LAMPMAN (522)

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): March 16, 17, 18, 19, 22, and 23, 2021.

During this inspection Complaint IL-87956-LO related to falls prevention and the home's skin and wound program was inspected.

PLEASE NOTE:

A Voluntary Plan of Correction (VPC) related to LTCHA, 2007 c.8, s. 6. (1)(c) was identified in this inspection and has been issued in Critical Incident System Inspection Report #2021_725522_0003, which was conducted concurrently with this inspection.

A VPC related to O. Reg. 79/10 s. 30. (1) 2 was identified in this inspection and has been issued in Inspection Report #2021_725522_0003.

A Written Notification related to O. Reg. 79/10, s. 8 (1) (b) was issued in this inspection as supporting evidence for Compliance Order #001 issued in Inspection #2020_563670_0032 with a Compliance Due Date of February 9, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, a Registered Nurse, Registered Practical Nurse and Personal Support Worker.

The inspector also observed staff to resident care, reviewed resident clinical records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care

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

- **2 WN(s)**
- **0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Skin and Wound Program: Wound Care Management and Prevention of Skin Breakdown" policies were complied with for resident #001.

This finding of noncompliance is further evidence to support compliance order #001 that was issued on November 12, 2020, during Complaint Inspection #2020_563670_0032 with a compliance due date of February 9, 2021.

O. Reg. 48 (1) 2. states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcer, and provide effective skin and wound care interventions."

Resident #001 sustained several areas of impaired skin integrity from a fall.

A) Review of Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy noted that on all shifts direct care staff were to observe the residents' head to toe skin condition and document altered skin integrity in the residents' Daily Care Record or electronic equivalent.

Review of the home's Documentation Survey report with the Director of Care (DOC) noted no documentation from Personal Support Workers (PSWs) that resident #001 had any altered skin integrity after their fall. The DOC stated PSWs should have noted that

resident #001 had altered skin integrity after their fall.

B) Review of Extendicare's "Skin and Wound Program: Wound Care Management" policy noted that a resident who exhibited any form of altered skin integrity, which included bruises, skin tears and wounds, received a skin assessment by a nurse using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and was to be reassessed at least weekly. The resident's treatment regimen was to be recorded on the resident's electronic Medication Administration Record (eMAR) or electronic Treatment Administration Record (eTAR).

Review of resident #001's clinical record in Point Click Care noted the absence of skin and wound assessments for resident #001's altered skin integrity.

In an interview, Registered Practical Nurse (RPN) #106 stated they attended to resident #001 after their fall but did not recall if they completed a skin and wound assessment for resident #001's altered skin integrity.

In an interview, Registered Nurse (RN) #108 acknowledged there were no skin and wound assessments completed for the impaired skin integrity resident #001 sustained from their fall and skin and wound assessments should have been completed.

Sources:
Resident #001's clinical records, Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy #RC-23-01-01 last updated August 2019 and Extendicare's "Skin and Wound Program: Wound Care Management" RC-23-01-02 last updated August 2019, interviews with PSW #105, RPN #106, RN #108 and the DOC. [s.8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1.The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of resident #001 occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to the improper care of resident #001. The complainant stated that resident #001 was transported without the required supports on their assistive device, causing resident #001 to fall and sustain altered skin integrity.

Review of the MLTC Long-Term Care Homes Portal noted there was no Critical Incident System (CIS) report submitted for the incident.

Review of resident #001's progress notes confirmed resident #001 had a fall when a PSW transported the resident without the required supports on their assistive device.

In an interview, the Director of Care (DOC) stated they did not submit a CIS report regarding resident #001 being transported improperly without the required supports on their assistive device which caused resident #001 to fall and sustain injuries. The DOC stated they had never submitted a CIS report for anything like that before.

Sources:
Review of the MLTC Long-Term Care Homes Portal, resident #001's clinical records and interviews with resident #001's SDM and the DOC. [s. 24. (1) 1.]

Issued on this 26th day of April, 2021

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

Original report signed by the inspector.