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

**Toronto District**
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# Original Public Report

**Report Issue Date:** December 09, 2022

**Inspection Number:** 2022-1496-0001

**Inspection Type:**
Critical Incident System

**Licensee:** Kristus Darzs Latvian Home

**Long Term Care Home and City:** Kristus Darzs Latvian Home, Woodbridge

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Parimah Oormazdi (741672) | Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2022.12.19 01:08:16 -05'00' |

**Additional Inspector(s)**
Stephanie Luciani (707428)

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 1, 2022
December 2, 2022
December 5, 2022
December 6, 2022

The following intake(s) were inspected:
- Intake: #00004816 - related to skin and wound care
- Intake: #00010853 - related to falls prevention and management

The following intakes were completed in the Critical Incident System Inspection:
- Intake: #00004550 - related to falls prevention and management
- Intake: #00004494 - related to falls prevention and management
- Intake: #00004839 - related to falls prevention and management

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management
Infection Prevention and Control

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: SKIN AND WOUND CARE

**NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

**The licensee failed to comply with O. Reg. 246/22, s. 55 (2)(b)(i)**

The licensee has failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

**Rationale and summary:**
The home submitted a Critical Incident System (CIS) report, related to allegations of improper skin and wound care for a resident.

The resident developed an area of altered skin integrity that required a treatment. However, no skin and wound assessment was carried out related to this area of altered skin integrity.

The Registered Practical Nurse (RPN) and the Director of Care, both stated that the skin and wound assessment tool should have been completed following the altered skin integrity being identified.

Failure to assess the resident's altered skin integrity placed them at risk for further deterioration of their skin integrity.

**Sources:** Resident's progress notes, plan of care and skin and wound assessment, interview with RPN and Director of Care. [741672]

## WRITTEN NOTIFICATION: SKIN AND WOUND CARE

**NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iii)

**The licensee failed to comply with O. Reg. 246/22, s. 55 (2)(b)(iii)**

The licensee has failed to ensure that a resident who exhibited altered skin integrity was assessed by registered dietitian who was a member of the staff of the home, and any changes made to resident's plan of care relating to nutrition and hydration were implemented.

**Rationale and summary:**
A resident developed an area of altered skin integrity. No assessment by a Registered Dietitian (RD) was identified related to this area of altered skin integrity.

The Registered Dietitian (RD) indicated that for the identified altered skin integrity, the resident's nutritional status should have been assessed by the RD. The RD had not been notified by nursing staff to complete an assessment of this altered skin integrity.

Director of Care (DOC) were not aware that residents with all types of altered skin integrity should be assessed by the Registered Dietitian.

By not assessing nutritional status of resident's altered skin integrity, the resident did not have nutritional interventions implemented. They were at risk of deterioration in their altered skin integrity as a result.

**Sources:** Resident's progress notes, plan of care and Nutrition assessment, interview with RD and Director of Care. [741672]

## WRITTEN NOTIFICATION: SKIN AND WOUND CARE

**NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iv)

**The licensee failed to comply with O. Reg. 246/22, s. 55 (2)(b)(iv)**

The licensee has failed to ensure that the resident's altered skin integrity was assessed at least weekly by a registered nursing staff.

**Rationale and summary:**
A resident developed an altered skin integrity and a treatment was initiated. A weekly skin and wound assessment of the resident did not contain assessment of the resident's skin impairment on affected area. No assessment of resident's altered skin integrity was carried out until 11 days after the area was identified.

The Registered Practical Nurse (RPN) and Director of Care, both stated that the altered skin integrity should have been assessed on the weekly skin and wound assessment. They acknowledged the skin and wound assessment was not completed weekly as indicated.

By not assessing resident's altered skin integrity weekly, the effectiveness of treatment could not be monitored and placed the resident at risk of deteriorating skin.

**Sources:** Resident's progress notes, plan of care and skin and wound assessments, interview with RPN and Director of Care. [741672]