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
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: January 10, 2024
Inspection Number: 2024-1435-0001
Inspection Type: Complaint
Licensee: Parkwood Mennonite Home Inc.
Long Term Care Home and City: Parkwood Mennonite Home, Waterloo

Lead Inspector	**Inspector Digital Signature**
Kailee Bercowski (000734)	Kailee Bercowski Digitally signed by Kailee Bercowski Date: 2024.01.10 14:48:52 -05'00'

Additional Inspector(s) None

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 4, 5, 8, 9, 2024

The following intake(s) were inspected:

- Intake: #00100482 - Complaint related to wound care.
- Intake: #00100474 - Complaint related to wound care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements for Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program, including interventions, were documented.

As per the home's Skin and Wound Management Program #NM006010.00, last revised September 2023, front line health care staff will provide routine care including turning and positioning. They are also to refer to individual tasks on the electronic medical record for specific care instructions.

Rationale and Summary
A resident had a wound, and required staff assistance for repositioning every two hours. Staff were to document this task, as well as observations of skin integrity, on the home's electronic medical record.

In the six month period, four months contained incomplete documentation of the repositioning task, including a two month discontinuation of the task.

The Skin and Wound Care Program Lead said the documentation gaps were likely due to clerical errors with the electronic medical record system, and was not as per the home's process.

When the resident's skin and wound care intervention was not documented, it was unclear whether the task was performed, or what factors contributed to the resident's altered skin integrity.

Sources: A resident's clinical records; Skin and Wound Program Policy #NM006010.00 (last revised September 2023), Interviews with the Skin and Wound Care Program Lead, and other staff.
[000734]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 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 failed to ensure a resident received weekly assessments of their wounds.

Rationale and Summary

A) A resident's skin tear was not assessed weekly after an identified date. A new pressure ulcer was identified in the same area a month later.

The Skin and Wound Care Program Lead said there was no documentation of the skin tear healing on the identified date, and the skin tear should have been monitored weekly afterwards.

B) During a five month period, a resident did not receive twelve weekly assessments for their wounds.

Six weekly wound assessments were missing, and six were not completed.

The Skin and Wound Care Program Lead said this was not as per the home's process.

Failure to complete weekly wound assessments put the resident at risk of undetected wound deterioration, and interventions not being applied in a timely manner.

Sources: A resident's clinical records; Interviews with the Skin and Wound Care Program Lead and other staff.
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