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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 28, 2024	
Inspection Number: 2024-1378-0001	
Inspection Type: Critical Incident	
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.	
Long Term Care Home and City: Sherwood Court Long Term Care Centre, Maple	
Lead Inspector Elaina Tso (741750)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5, 6, 7, 8, 14, 2024.

The following intake(s) were inspected:

- An intake related to a fall resulting in injury.

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

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

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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 with altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:
A Critical Incident Report was submitted to the Director related to a resident's fall that resulted in a significant change in their health condition and required medical intervention.

The resident was discharged back to the Long-Term Care Home with a surgical wound. An initial skin and wound assessment for the resident was completed. However, there was no further documentation of completed weekly skin and wound assessments for the resident's surgical wound for more than a week.

The Skin and Wound Lead confirmed that the weekly skin and wound assessment was not completed for the resident's surgical wound. The Skin and Wound Lead further confirmed that the resident's surgical wound was not healed. The

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expectation was to complete the weekly skin and wound assessment until the wound is healed.

Failure to complete a weekly skin and wound assessment might have prevented the staff from monitoring the wound, posing a risk for prolonged wound healing.

Sources: resident's health records, and interview with the Skin and Wound Lead. [741750]