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: July 11, 2023	
Inspection Number: 2023-1466-0003	
Inspection Type: Complaint	
Licensee: Arirang Age-Friendly Community Centre	
Long Term Care Home and City: Arirang Korean Long Term Care, Toronto	
Lead Inspector Kehinde Sangill (741670)	**Inspector Digital Signature** Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2023.07.26 16:35:31 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27-30, 2023, and July 5, 2023.

The inspection occurred offsite on the following date(s): July 6, 2023.

The following intake(s) were inspected:

- Intake: #00089226 - Complaint related to alleged neglect of a resident.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in different aspects of a resident's care, collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident was admitted with skin impairment and identified as high risk for altered skin integrity. Entries made in the physician's communication sheets related to the resident did not mention the skin impairment. Progress notes showed inconsistent treatments were provided by various registered staff for the same area of altered skin integrity.

A RPN (Registered Practical Nurse) stated that the physician was not informed about the skin impairment because they did not feel it was significant. The RPN noted that the nurse has the discretion to decide on treatment for insignificant altered skin integrity.

A RN (Registered Nurse) and the Nurse Manager (NM) stated that staff are required to inform the physician of residents with areas of altered skin integrity. The NM noted that the physician should have been informed of the skin impairment and a treatment order obtained. The NM also indicated that inconsistent treatment for the area of altered skin integrity was due to failure of communication between registered staff.

Staff's failure to collaborate with the physician in the care of the resident's skin impairment may have resulted in inconsistencies in providing treatment and intervention to promote healing.

Sources: Resident's clinical records, Physician's Communication Sheets; and staff interviews.
[741670]

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) (i)

The licensee has failed to ensure that a resident, who was exhibiting 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

A resident was admitted into the home with an area of altered skin integrity. Initial skin and wound assessment was not completed for the identified area of skin impairment.

Two RPNs verified that a skin and wound assessment was not done. One of the RPNs indicated they felt it was not necessary as the area of skin impairment was very small.

A RN indicated that staff are required to complete a skin and wound assessment and a progress note when an area of altered skin integrity is initially identified on a resident. The RN acknowledged that a skin and wound assessment should have been completed when the area of skin impairment was identified.

The NM acknowledged that registered staff did not use a clinically appropriate tool to assess the area of altered skin integrity.

Failure to complete an initial skin and wound assessment for the resident may have hindered staffs' ability to effectively monitor the resident's skin status and provide effective treatment.

Sources: Resident's clinical records; and staff interviews.
[741670]

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 (2) (b) (ii)

The licensee has failed to ensure that a resident received immediate treatment and interventions for their altered skin integrity to promote healing and prevent infection.

Rationale and summary

A resident was identified with skin impairment upon admission. A progress note written six days later indicated that the resident received treatment for an area of altered skin integrity. There was no treatment record prior.

A RPN indicated there was a dressing on an area of skin impairment when resident was admitted. The RPN acknowledged that the dressing was not removed, and treatment and intervention were not initiated for the identified area of altered skin integrity.

The NM verified that the resident did not receive immediate treatment for the skin impairment present on admission. The NM stated that staff should have cleaned the area and provided temporary treatment until the physician was notified and able to assess.

Failure to initiate immediate treatment and intervention to the resident's area of altered skin integrity may have impacted healing.

Sources: Resident's clinical records; and staff interviews.
[741670]

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) (iv)

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

Rationale and Summary

A resident was admitted with an area of skin impairment. References were made to this area of skin impairment in the progress notes three times within a six-week period. However, no skin and wound assessments were completed for this area of altered skin integrity.

The NM stated that weekly skin and wound assessments were indicated because it took a long period for the skin impairment to heal. The NM acknowledged that a weekly skin and wound assessment was not completed for the resident for the duration of their stay in the home.

The Director of Care (DOC) stated that staff are required to complete a weekly skin assessment as per procedure when a skin problem is identified. The DOC also noted that re-education about the definition of altered skin integrity and procedure was needed.

The home's Preventative Skin Care Program policy directed registered staff to assesses all skin conditions weekly and document on Skin and Wound Note in the progress note section of Point Click Care (PCC).

Failure to complete weekly skin and wound assessment for the resident increased the risk of changes in skin impairment not being identified and addressed in a timely manner.

Sources: Resident's clinical records, Wound Care Program policy (Sec 4.16.1, Last reviewed March 2023); and staff interviews.
[741670]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that Personal Support Workers (PSWs) participated in the implementation of the home's IPAC program related to hand hygiene.

Rationale and Summary

During dining room observation on a specified day, two PSWs were observed providing feeding assistance to multiple residents at separate tables at mealtime. Both PSWs did not perform hand hygiene (HH) when moving from one resident to another.

One of the PSWs acknowledged that they did not perform HH when moving between residents because they did not know they were required to.

The second PSW acknowledged they were aware they needed to perform HH when moving between residents but failed to do so because they were in a hurry.

The IPAC Lead acknowledged that staff are expected to perform HH when moving from assisting one resident to another to prevent the transmission of infection between residents.

Staff failure to perform HH when moving between residents increased the risk of transmission of infection.

Sources: Observations in the home; and staff interviews.
[741670]