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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 15, 2023	
Inspection Number: 2023-1211-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: 488491 Ontario Inc.	
Long Term Care Home and City: Avalon Retirement Centre, Orangeville	
Lead Inspector Robert Spizzirri (705751)	**Inspector Digital Signature**
Additional Inspectors Diane Schilling (000736) was present at this inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 27-28, March 1-2, 6-10, and 13, 2023.

The following intakes were inspected:

- Intake: #00003789 related to fall management and prevention.
- Intake: #00018883 (complaint) related to infection prevention and control, hydration, and skin and wound.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
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)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were reassessed weekly as clinically indicated.

Rationale and Summary

The homes Skin and Wound Care Program policy stated when a resident has actual alteration to their skin integrity, a skin and wound evaluation assessment was to be completed. The policy indicated that all documentation is required to complete the wound assessment. It directed staff to lock the assessment once complete so a progress note generates and specified that a skin and wound evaluation may be required weekly.

The skin and wound evaluation included a description of the wound, measurements, assessment of the wound bed, exudate, peri-wound, wound pain, orders, treatment, and progress.

A resident had multiple areas of actual alterations in skin integrity. Each area required a weekly skin assessment.

Upon review it was discovered that multiple assessments documented were incomplete.

The Nurse Practitioner (NP) said that they review information provided in progress notes and that the assessments do not always contain the required level of detail.

The Skin and Wound Lead acknowledged that the assessments were not completed.

When staff do not complete their assessments there was insufficient information available to those reviewing them to determine the need for assessment and/or change in treatment plan.

Sources: Skin and wound evaluations assessments, Skin and Wound Care Program Policy (04/08/2022), interviews with Skin and Wound lead, NP, and others.

[705751]