Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 6, 2022	2021_911506_0010	016373-21, 019051-21	Complaint

Licensee/Titulaire de permis

Dover Cliffs Operating Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Dover Cliffs
501 St. George Street P.O. BOX 430 Port Dover ON N0A 1N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 8, 9, 10, 14, 15 and 17, 2021.

This inspection was completed related to the following Complaint intakes:

Log #016373-21- related to skin and wound; and
Log #019051-21- prevention of abuse and neglect.

This inspection was conducted concurrently with Critical Incident Inspection #2021_911506_0009.

During the course of the inspection, the inspector(s) spoke with Executive Director, Associate Director of Care (ADOC), Infection Control Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Environmental Service Manager (ESM), Dietary Aides, Nurse Practitioner (NP), Registered Dietitian and residents.

During the course of the inspection the inspector toured the home, reviewed clinical records, consult notes, policies and procedures, observed the provision of care and conducted interviews.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident.

A review of the resident's written plan of care did not include any goals or interventions for altered skin integrity.

The Associate Director of Care (ADOC) confirmed that the information about the resident's altered skin integrity including interventions, were not included in the resident's written plan of care which front line staff use to direct care.

The resident with altered skin integrity was at risk for further skin/wound breakdown when staff did not develop a written plan of care that included interventions to maintain their skin integrity.

Sources: resident's clinical record and interview with ADOC. [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

The home's policy "Skin and Wound Care" policy directed registered staff to document weekly re-evaluation and wound progress by using the skin and wound application.

A resident had an area of altered skin integrity. A review of the clinical record identified that from specific dates reviewed, the resident had missed weekly wound assessments.

The risk of not completing weekly wound assessments for the resident was that staff could not evaluate if the wound was worsening or required new treatment.

Sources: resident's skin and wound assessments; interview with ADOC and the home's policy for Skin and Wound Care " (last reviewed March 2020). [s. 50. (2) (b) (iv)]

Issued on this 11th day of January, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.