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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 16, 2024
Inspection Number: 2024-1030-0003
Inspection Type: Complaint
Licensee: Dover Cliffs Operating Inc.
Long Term Care Home and City: Dover Cliffs, Port Dover

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.04.16 10:44:01 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00112566, complaint related to specific resident care concerns.

Inspector Aby Thomas (000830) was present during this inspection.

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

Skin and Wound Prevention and Management
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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

Rational and Summary:
A clinical record review for a resident showed a skin and wound assessment was completed on a specific date, for a new skin integrity concern. The treatment section of the assessment included a specific treatment to be completed.

A clinical record review of the Electronic Treatment Administration Records (ETAR) showed the specific intervention was not documented until several days later.

In an interview the Assistant Director of Care (ADOC) said the treatment should have been added to the plan of care in ETAR on the day of the assessment. They said the plan of care at that time was not based on the assessment of the resident as it did not include the treatment plan as per the assessment.

Sources: clinical records and staff interviews. [523]

WRITTEN NOTIFICATION: Skin and Wound Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the skin and wound program was complied with.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee was required to ensure the skin and wound program policies and procedures were complied with.

A review of the skin and wound program policies, a clinical record reviews and staff interviews showed the staff did not comply with the specific skin and wound program policies when the staff did not inform the Power of Attorney (POA) about new or worsening skin concerns.

In an interview the ADOC said the expectation was for the staff to notify the POA if the resident had a new or worsening skin concerns. The ADOC said the staff did not comply with the home's policy.

Sources: record reviews and staff interviews. [523]