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

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

Original Public Report

Report Issue Date: December 8, 2023	
Inspection Number: 2023-1081-0003	
Inspection Type: Critical Incident	
Licensee: CVH (No. 8) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Errinrung Long Term Care Home, Thornbury	
Lead Inspector Gabriella Del Principe (741734)	Inspector Digital Signature Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.12.19 08:52:35 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 20-23, 27, 29, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00089567 was related to resident care
- Intake #00095579 was related to an outbreak

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation of Interventions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that interventions implemented after a skin and wound care assessment was completed for a resident was documented in the resident's plan of care.

Rationale and Summary

A Registered Nurse (RN) found a skin impairment on a resident during a skin assessment. Two staff members indicated that an intervention was implemented to prevent skin breakdown.

A review of the resident's clinical health records demonstrated that the intervention implemented was not documented in their plan of care.

A Registered Practical Nurse (RPN) and the Executive Director indicated that any skin impairment and the associated interventions were expected to be documented in the resident's medication administration record (MAR) or treatment administration record (TAR).

Failure to document the interventions in the resident's plan of care placed the

resident at risk as treatment and care was not clearly identified and communicated among staff members.

Sources: Resident's clinical health records (electronic and paper), Skin and Wound Program: Wound Care Management Policy (RC 23-01-02), and interviews with a Personal Support Worker (PSW), RPN, RN, and the Executive Director. [741734]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to include the status of staff member(s) involvement in an incident, within the critical incident submitted to the Director.

Summary and Rationale

The home submitted a critical incident to the Director, regarding the concerns brought forward from a resident's family member.

The home conducted an investigation to address the concerns.

A review of the critical incident report demonstrated that the entire outcome of the investigation was not included.

Failure to provide this information within the critical incident report may have prevented the Director from responding accordingly and in a timely manner.

Sources: Critical Incident report, and interview with the Executive Director. [741734]