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
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 14, 2022	
Inspection Number: 2022-1332-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Brampton, Brampton	
Lead Inspector Amanpreet Kaur Malhi (741128)	**Inspector Digital Signature**
Additional Inspector(s) Kim Byberg (729) Yami Salam was present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 31, 2022 - November 4, 2022

The following intake(s) were inspected during this Critical Incident (CI) inspection:

- Intake: #00001408 related to fall from a resident resulting in their transfer to hospital and significant change in their status

The following intake(s) were inspected during this Complaint inspection:

- Intake: #00007639 related to plan of care

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

Medication Management

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Safe and Secure Home
Falls Prevention and Management
Infection Prevention and Control
Skin and Wound Prevention and Management

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 (1) 2.

The licensee has failed to ensure that the skin and wound care program provided a resident with strategies to prevent infection from developing in their wounds.

Rationale and Summary
A resident was identified as having a wound that required daily dressing changes by the nursing staff.

The wound care supplies were left in a basket in the resident’s room with the packages open. The wound care supplies were exposed to other items in the basket.

The home’s skin and wound care lead stated that the staff used the products to clean and treat the wound. They stated that the supplies should have been thrown out as they were open, exposed, and not in a sealed package.

The resident's wound had worsened since and required treatments on two previous occasions for infection. Having opened and exposed dressing supplies could have increased the risk of infection and the resident being exposed to harmful bacteria.

Sources:
Interview with the home’s skin and wound lead, DOC, electronic medication administration record (eMAR), Skin and Wound assessments.

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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)(iv)

The licensee has failed to ensure that when a resident had a wound, they were assessed weekly by a registered nursing staff member.

Rationale and Summary

A resident had a wound that required skin care and dressing changes to be completed daily. There were no weekly skin and wound assessments completed.

The home's skin and wound care lead stated that the weekly skin and wound assessments should have been completed.

When the home did not complete weekly assessments of the resident's impaired skin integrity, the risk of complications related to the impaired skin integrity may not have been identified and treatment initiated immediately.

Sources: Interview with the skin and wound care lead, DOC, RPN, resident, record review of the skin and wound assessments, Policy titled “Skin and Wound Program: Wound Care Management” Last reviewed January 2022, EMAR.

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