

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: July 7, 2023	
Inspection Number: 2023-1018-0003	
Inspection Type: Follow up Critical Incident System	
Licensee: ATK Care Inc.	
Long Term Care Home and City: The Fordwich Village Nursing Home, Fordwich	
Lead Inspector Amanpreet Kaur Malhi (741128)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): June 28-30 and July 4-5, 2023</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake #0008707, related to Follow-up compliance order #1 - FLTCA, 2021 - s. 24 (1) Intake #00088195, related to falls
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Previously Issued Compliance Order(s)

The following previously issued Compliance order were found to be in compliance:
Compliance Order #1 from Inspection #2023-1018-0002 related to FLTCA, 2021, s. 24 (1), inspected by Amanpreet Kaur Malhi (741128)

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- 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) (i)

The licensee failed to assess resident #002's area of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

Resident #002's area of altered skin integrity did not have an assessment using a clinically appropriate tool completed.

DOC #100 said that the skin assessment was not completed and stated that the staff are expected to complete the skin assessment for the identified altered skin integrity.

By not completing the skin assessment of resident #002's area of altered skin integrity using the clinically appropriate skin assessment documentation tool, the risk of complications related to the impaired skin integrity may not have been effectively monitored.

Sources: Resident #002's clinical records and Interview with DOC #100

[741128]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that resident #002's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, when it was not relieved by the as needed (PRN) pain medication.

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Rationale and Summary

Resident #002's pain was not relieved by the PRN pain medications.

RN #104 and DOC #100 said that the comprehensive pain assessment was not completed for resident #002 and should have been.

Without a comprehensive pain assessment, resident #002's pain may not have been treated effectively.

Sources: Resident #002's clinical records, Pain Identification and Management Policy RC-19-01-01, last updated: December 2019, Interview with RN #104 and DOC #100

[741128]