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

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Original Public Report

Report Issue Date: July 17, 2024

Inspection Number: 2024-1587-0002

Inspection Type:
Complaint

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Sunset Manor Home for Senior Citizens, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 18-20, 25-28, 2024 and July 2-5, 2024.

The following Critical Incidents (CI) were completed in this inspection:

- Intake #00115952, CI #M581-000027-24 and Intake #00117258/ CI #M581-000031-24, related to improper/incompetent treatment of a resident

The following Complaints were completed in this inspection:

- Intake #00115598, related to skin and wound care concerns
- Intake #00116274, related to plan of care concerns
- Intake #00118931, related to skin and wound care concerns

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care-Involvement of Resident and Designate

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's Power of Attorney (POA) was informed when there was a change in a resident's wound.

Rationale and Summary

A resident's POA was not informed when a residents skin impairment worsened.

Failure to communicate wound care changes to the resident's POA in a timely manner prevented them from advocating for the resident and participating in the

development of the plan of care at that time.

Sources: A resident' clinical health records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 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.

A. The licensee failed to ensure that a resident's skin and wound assessments were documented appropriately and accurately.

Rationale and Summary

A resident had a wound. A review of the resident's weekly skin and wound assessments demonstrated that there were inconsistencies within the completed weekly assessments for this wound, particularly the primary dressing applied to the resident's wound.

The Skin and Wound Care Lead acknowledged the inconsistencies and identified that the completion of the skin and wound weekly assessment tool by registered staff members was the source of the inconsistencies in documentation.

Failure to ensure that a resident's weekly skin and wound assessments were

accurately and appropriately documented could have prevented the home from monitoring the effectiveness of the resident's current interventions and prevented the home from ensuring that the resident received the intended care as specified in their plan of care.

Sources: A resident's clinical health records, and interviews with staff.

B. The licensee failed to ensure that an intervention for a resident's wound care was documented.

Rationale and Summary

A resident's records included an order from the Physician regarding when the resident required a wound dressing change on an as needed basis.

Twice the resident's records indicated that a registered staff member was informed that the resident's wound dressing was not applied and required attention. Further review of the resident's records demonstrated that documentation of a wound dressing change was not administered on these identified dates.

The Skin and Wound Care lead indicated that when a resident requires a wound dressing change on an as needed basis, a registered staff member (Registered Practical Nurse (RPN) or Registered Nurse (RN)) would complete the dressing change, and this should be documented in the resident's Treatment Administration Record (TAR). The Skin and Wound Care Lead acknowledged that documentation was missing on these identified dates.

Failure to document the provision of care prevented the home from ensuring that the resident's wound care needs were sufficiently met and was provided the

required care when a concern was identified.

Sources: A resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Transferring

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that the proper technique for assisting a resident was implemented during a transfer.

Rationale and Summary

A resident's records included specific instructions for operating their mobility device during transfers.

A Personal Support Worker (PSW) failed to follow the instructions for the resident's mobility device during a transfer, which caused discomfort and an injury to the resident.

Sources: A resident's clinical health records, observations of the resident's room and transfer area, and interviews with the resident and staff.

WRITTEN NOTIFICATION: Skin and Wound Assessments

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that weekly skin and wound assessments were completed for a resident.

Rationale/Summary

A new skin impairment was identified for the resident.

Records demonstrated two instances in which weekly skin and wound assessments were not completed.

Director of Resident Care (DRC) #112 confirmed that skin and wound assessments for the resident were not completed on the identified dates, and should have been.

Failure to consistently complete a weekly skin and wound assessment placed the resident at risk, as there could have been delayed detection, treatment and care of the resident's wound.

Sources: A resident's clinical health records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Availability of Supplies

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee failed to ensure that a wound care supply was readily available and implemented for a resident.

Rationale and Summary

The home's Physician assessed a resident's wound and implemented a wound care intervention to assist with healing that required a specific supply.

The Physician and a member of the home's management staff discussed the acquisition of the supply and the implementation of the intervention for the resident.

Approximately one month later, it was identified that the supply had not been available and the intervention had not been implemented, as per the Physician's instructions.

DRC #101 and DRC #112 confirmed that due to gaps in communication, the supply was not ordered and was not available in the home for the resident. Additionally, registered staff members did not bring forward any concerns regarding the lack of availability of the wound care supply, and should have.

Failure to ensure that the appropriate wound care supplies were available and accessible in the home prevented the resident from receiving a recommended treatment for wound care, to promote wound healing.

Sources: A resident's clinical health records, investigation notes, observation of wound care treatment supply cart, and interviews with staff.